

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27501

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

William K. Thompson

2. Date of Death

Month  
AugDay  
12Year  
2000

3. Time of Death

8:15 PM

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

5. Social Security Number

578-01-3944

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb 28, 1917

9. Birthplace (State or Foreign Country)

NC

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George's

10c. City, Town or Location

Adelphi

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

8503 14th Avenue

10f. Zip Code

20783

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☒ Yes ☐ No

If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Carpenter Foreman

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

William K. Thompson

18. Mother's Name (First, Middle, Maiden Surname)

Jetta Shaw

19a. Informant's Name/Relationship (Type, Print)

Gertrude N. Thompson/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8503 14th Avenue, Adelphi, MD 20783

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Arlington National Cemetery

Date

8/23/00

20c. Location - City or Town, State

Arlington, VA

21. Signature of Funeral Service Licensee

Tracy A. Stover

22. Name and Address of Facility

Francis J. Collins Funeral Home

500 University Blvd. W.

Silver Spring MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. CARDIAC ARREST

Due to (or as a consequence of):

c. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☒ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

Hospital:

☐ Inpatient☒ Outpatient☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Pending☐ Accident☐ Suicide☐ Homicide

investigation

☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at

Work?

☐ Yes ☒ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Medical Examiner☐ Physician29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

James Buxbaum

29c. License number

D0035427

29d. Date signed (Month, Day, Year)

8-13-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James Buxbaum MD, 9210 Corporate Blvd. Suite 210, Rockville MD 20850

31. Date filed (Month, Day, Year)

AUG 17 2000

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27502

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Claressa Poole Thompson				2. Date of Death Month Day Year August 12, 2000				3. Time of Death 5:00 PM	
	4a. Facility Name (If not institution, give street and number) Suburban Hospital				4b. City, Town, or Location of Death Bethesda				4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 229-44-4747		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 61 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 12, 1938		9. Birthplace (State or Foreign Country) Virginia	
	Usual Residence of Decedent									
10a. State Md		10b. County Montgomery		10c. City, Town or Location Silver Spring				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 14508 Banquo Terrace				10f. Zip Code 20906		10g. Citizen of What Country? United States				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Educator				16b. Kind of Business/Industry Education		
17. Father's Name (First, Middle, Last) James Poole				18. Mother's Name (First, Middle, Maiden Surname) Adamae Wilson						
19a. Informant's Name/Relationship (Type, Print) Kimani M. Thompson/Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14508 Banquo Terrace Silver Spring, Md 20906						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Parklawn Cemetery		Date 8/17/00		20c. Location - City or Town, State Rockville, Md.		
21. Signature of Funeral Service Licensee Andre Thompson				22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Avenue, N.W. Wash., D.C. 20012						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multisystem ORGAN Failure Due to (or as a consequence of): Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.										
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. metastatic cancer pneumonia										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
				28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier Bobby Sherrin				29c. License number 20562				29d. Date signed (Month, Day, Year) August 13, 2000		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) BRIAN J. LEVIN, 10215 Fernwood Rd Bethesda Md										
31. Date filed (Month, Day, Year) AUG 16 2000				32. Registrar's Signature B. Sparks						



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State of Maryland / Department of Health and Mental Hygiene

00 27503

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Dexter T. Thomas

2. Date of Death  
Month Day Year  
August 10 20003. Time of Death  
4:45 pm

4a. Facility Name (If not institution, give street and number)

Genesis Eldercare - Layhill Center

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

578-10-6759

6. Sex

15 M 2 F

7. Age (In yrs. last birthday)

95

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct. 24, 1904

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

3203 Hewitt Avenue #204

10f. Zip Code

20906

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married  
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

1 Yes 2 No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Bus Driver

16b. Kind of Business/Industry

Transportation

17. Father's Name (First, Middle, Last)

Daniel L. Thomas

18. Mother's Name (First, Middle, Maiden Surname)

Sarah L. Nolen

19a. Informant's Name/Relationship (Type, Print)

Mary Jane Gray (step-daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4111 Independence Street Rockville, Maryland 20853

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State  
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parklawn Memorial Park

Date

8/14/00

20c. Location - City or Town, State

Rockville, Maryland

21. Signature of Funeral Service Licensee

Andrew J. Cole

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 week

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

26. Place of Death (Check only one)

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

Other:

4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide  
5 Pending investigation 6 Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. A. Mendhiratta

29c. License number

D38262

29d. Date signed (Month, Day, Year)

August 12, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr A MENDHIRATTA 2401 Research BLVD Suite 340 md 20854

State  
Registrar

31. Date filed (Month, Day, Year)

AUG 14 2000

32. Registrar's Signature

Benita B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



NIHAN TULAZHAR

State of Maryland / Department of Health and Mental Hygiene

00-4617-047

AMEND ITEMS: #23 PART I, 27 PER MEO

Certificate of Death

Reg. No.

00 27504

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>NIMAN TULADHAR</b>		2. Date of Death Month Day Year <b>AUGUST 16, 2000</b>		3. Time of Death <b>1118 AM</b>	
4a. Facility Name (If not institution, give street and number) <b>ATLANTIC GENERAL HOSPITAL</b>			4b. City, Town, or Location of Death <b>BERLIN</b>		4c. County of Death <b>WORCESTER</b>
5. Social Security Number <b>None</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>22</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Feb. 5, 1978</b>
Usual Residence of Decedent		9. Birthplace (State or Foreign Country) <b>Nepal</b>			
10a. State <b>None</b>	10b. County <b>None</b>	10c. City, Town or Location <b>Bhinsengola, Nepal</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>Kathmandu - 34</b>		10f. Zip Code <b>None</b>		10g. Citizen of What Country? <b>Nepal</b>	
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>Asian</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Student</b>	
17. Father's Name (First, Middle, Last) <b>Nirmal Tuladhar</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Suman Tuladhar</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Manil Maskey - Friend</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1004 Ridgely Avenue-Fairmont, West Virginia 26554</b>			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Kathmandu Crematory 8/28/2000</b>		20c. Location - City or Town, State <b>Kathmandu, Nepal</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Arlington Funeral Home-Arlington, Va. 22203 3901 North Fairfax Drive</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>CARDIAC ARRHYTHMIA</b>  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b>		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			
28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number <b>OCME</b>		29d. Date signed (Month, Day, Year) <b>AUGUST 17, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JACK M. TINS, M.D. 111 Penn Street, Baltimore, Maryland 21201</b>					
31. Date filed (Month, Day, Year) <b>AUG 30 2000</b>		32. Registrar's Signature 			





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27505

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Daniel Uggowitzer</i>				2. Date of Death Month <i>8</i> Day <i>23</i> Year <i>00</i>		3. Time of Death <i>2:30 pm</i>	
	4a. Facility Name (If not institution, give street and number) <i>University of Maryland</i>				4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death	
Funeral Director	5. Social Security Number <i>none</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. <i>2</i>		8. Date of Birth (Month, Day, Year) <i>8/20/00</i>	
	9. Birthplace (State or Foreign Country) <i>Maryland</i>		10a. State <i>MD</i>		10b. County <i>Carroll</i>		10c. City, Town or Location <i>Westminster</i>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <i>700 Gander et</i>		10f. Zip Code <i>21157</i>		10g. Citizen of What Country? <i>U.S.A.</i>	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>white</i>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>-0-</i> Collega (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>none</i>		16b. Kind of Business/Industry <i>none</i>			
	17. Father's Name (First, Middle, Last) <i>Peter Gustav Uggowitzer</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Robin Uggowitzer</i>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <i>Dr. Peter G. Uggowitzer (father)</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>700 Garden Court, Westminster, MD 21157</i>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Dulaney Valley Memorial Gdns</i>		20c. Location - City or Town, State <i>Timonium, Maryland</i>		20d. Date <i>Aug. 26 2000</i>	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <i>Brian T. Chisholm Funeral Services of Dulaney Vall 200 E. Padonia Road, Timonium, MD 21093</i>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  <i>a. Congenital Heart Defect</i> Due to (or as a consequence of): <i>b. trisomy 13</i> Due to (or as a consequence of):  <i>c.</i> Due to (or as a consequence of):  <i>d.</i>				Approximate Interval Between Onset and Death  <i>3 days</i> <i>3 days</i>			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>omphalocoele</i>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>[Signature] Neonatologist</i>			
To Be Completed by Physician/Medical Examiner	29c. License number <i>D48175</i>				29d. Date signed (Month, Day, Year) <i>8/23/00</i>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Andres Rodriguez MD 22 Greene St Baltimore MD</i>				31. Data filed (Month, Day, Year) <i>AUG 30 2000</i>			
To Be Completed by Physician/Medical Examiner	32. Registrar's Signature <i>[Signature]</i>				33. State Registrar <i>AUG 30 2000</i>			

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27506

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ANDREW NED WOYEVOVDSKY

2. Date of Death

Month Day Year  
AUGUST 13 2000

3. Time of Death

1:30p.m.

4a. Facility Name (If not institution, give street and number)

National Institute of Health

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

577-08-4145

6. Sex

M 2 F

7. Age (In yrs. last birthday)

32

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
April 1, 1968

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

D.C.

10b. County

none

10c. City, Town or Location

Washington, D.C.

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

2853 Ontario Road, N.W.

10f. Zip Code

20009

10g. Citizen of What Country?

USA

11. Marital Status

1 Yes 2 Married  
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 Yes 2 No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

Collage (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Interior Designer

16b. Kind of Business/Industry

Interior Design

17. Father's Name (First, Middle, Last)

Michael Woyevodsky

18. Mother's Name (First, Middle, Maiden Sumame)

Caroline Hewson

19a. Informant's Name/Relationship (Type, Print)

Caroline McDermott/mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14526 Storybook Lane, Amissville, Va. 20106

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State  
4 Donation 5 Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metropolitan Crematory Aug. 14, 00

Date

20c. Location - City or Town, State

Alex., Va.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DeVol Funeral Home

2222 Wisconsin Ave., N.W., Wash., DC 20007

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. HODGKIN'S LYMPHOMA

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

2 YEARS

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. HIV

Due to (or as a consequence of):

YEARS

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy  
performed?

1 Yes 2 No

24b. Were autopsy findings  
available prior to  
completion of cause  
of death?

1 Yes 2 No

25. Was case referred to medical  
examiner?

1 Yes 2 No

26. Place of Death (Check only one)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 5 Pending  
2 Accident 6 investigation  
3 Suicide 6 Could not be  
4 Homicide 6 datamined

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?

1 Yes 2 No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner as stated.

29b. Signature and title of certifier

29c. License number

01051108 (INDIANA)

29d. Date signed (Month, Day, Year)

8/13/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MINOCHER BATTIWALLA 9000 ROCKVILLE PIKE, BETHESDA MD, 20892

State  
Registrar

31. Date filed (Month, Day, Year)

AUG 16 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27507

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Hilda M. Willing

2. Date of Death

August 14, 2000

3. Time of Death

5:00am

4a. Facility Name (If not institution, give street and number)

Wilson Health Care Center

4b. City, Town, or Location of Death

Gaithersburg

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

212-60-2079

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

102 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Mar. 31, 1898

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

301 Russell Avenue

10f. Zip Code

20877

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married  
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
7

College (14 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Severn C. Parks

18. Mother's Name (First, Middle, Maiden Surname)

Cora Phoebus

19a. Informant's Name/Relationship (Type, Print)

Mary K. Barrow (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

415 Russell Avenue #1112, Gaithersburg, MD 20877

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metropolitan Crematory

Date

8/14/00

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DeVol Funeral Home  
10 East Deer Park Drive  
Gaithersburg, MD 2087723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. pneumonia

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

weeks

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

chronic obstructive lung disease

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☒ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending  
investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicide ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?☐ Yes ☒ No28e. Place of Injury - At home, term, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

MD 20148

29d. Date signed (Month, Day, Year)

August 14, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Steven Dolinsky 911 Russell Ave. Gaithersburg, Md. 20879

31. Date filed (Month, Day, Year)

AUG 15 2000

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27508

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

PEGGY L. WHEELER

2. Date of Death

Month Day Year  
AUGUST 11, 2000

3. Time of Death

9:00 AM

4a. Facility Name (If not institution, give street and number)

739 Monroe Street, #201

4b. City, Town, or Location of Death

Rockville

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

215-38-6871

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

61 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 19, 1938

9. Birthplace (State or Foreign Country)

N. Carolina

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

739 Monroe Street, #201

10f. Zip Code

20850

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8th

College (14 or 5+)

15a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Waitress

15b. Kind of Business/Industry

Restaurant

17. Father's Name (First, Middle, Last)

Glenn R. Pritchard

18. Mother's Name (First, Middle, Maiden Surname)

Beatrice M. Hicks

19a. Informant's Name/Relationship (Type, Print)

Mark A. Anderson (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19510 Twinflower Cir., Germantown, MD 20876

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Boys Presby. Cem.

Date

8/16/00

20c. Location - City or Town, State

Boys, MD

21. Signature of Funeral Service Licensee

*Carla R. Brunker*

22. Name and Address of Facility

SNOWDEN FUNERAL HOME, P.A.

ROCKVILLE, MD 20850

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Myocardial infarction*  
*Due to (or as a consequence of)*  
b. *arteriosclerosis*

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c.   
Due to (or as a consequence of):  
d.   
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Frank Westphal MD  
Rockville, MD 20851

29c. License number

D0019785

29d. Date signed (Month, Day, Year)

8/14/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Frank Westphal MD  
Rockville, MD 20851

31. Date filed (Month, Day, Year)

AUG 15 2000

32. Registrar's Signature

*B. Sparks*State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27509

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) <b>LAWRENCE HARRY WATSON</b>				2. Date of Death Month Day Year <b>AUG 15 2000</b>		3. Time of Death <b>4:04 PM</b>	
4a. Facility Name (If not institution, give street and number) <b>NATIONAL NAVAL MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>BETHESDA</b>		4c. County of Death <b>MONTGOMERY</b>	
5. Social Security Number <b>001-09-2505</b>		6. Sex <b>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F</b>		7. Age (In yrs. last birthday) <b>82</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Nov. 4, 1917</b>	
9. Birthplace (State or Foreign Country) <b>Vermont</b>		10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Bethesda</b>	
10d. Inside City Limits <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>		10e. Street and Number <b>4509 Chase Avenue</b>		10f. Zip Code <b>20814</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <b>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married</b> <b>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b> If Yes, Give Year or Dates: <b>1937-59</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Hospital Corpsman</b>		16b. Kind of Business/Industry <b>United States Navy</b>			
17. Father's Name (First, Middle, Last) <b>George Watson</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Viola Hackett</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Margaret Giles Watson/Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4509 Chase Avenue, Bethesda, Maryland 20814</b>			
20a. Method of Disposition <b>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State</b> <b>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arlington National Cemetery</b>		Date <b>August 29, 2000</b>		20c. Location - City or Town, State <b>Arlington, Virginia</b>	
21. Signature of Funeral Service Licensee 		M01126		22. Name and Address of Facility <b>Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. PULMONARY EMBOLISM</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>							Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown</b>	
						24e. Was an autopsy performed? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>	
						24b. Were autopsy findings available prior to completion of cause of death? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>	
25. Was case referred to medical examiner? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>		26. Place of Death (Check only one) Hospital: <b>1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b> Other: <b>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b>					
27. Manner of Death <b>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</b> <b>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined</b>		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>	
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29e. Certifier (Check only one) <b>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>							
29b. Signature and title of certifier  <b>20 + 1</b>				29c. License number <b>042837 (GA)</b>		29d. Date signed (Month, Day, Year) <b>8/16/00</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MELANIE L. GUERRERO, CAPT, MC, USA</b>				<b>NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600</b>			
31. Date filed (Month, Day, Year) <b>AUG 18 2000</b>		32. Registrar's Signature 					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27510

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>FREDDIE L. WHEATLEY</b>		2. Date of Death Month <b>August</b> Day <b>5</b> Year <b>2000</b>		3. Time of Death <b>2347</b>
4a. Facility Name (If not institution, give street and number) <b>Prince George's Medical Center</b>		4b. City, Town, or Location of Death <b>Cheverly</b>		4c. County of Death <b>Prince George's</b>
5. Social Security Number <b>226-30-3069</b>	6. Sex <b>1 M 2 F</b>	7. Age (In yrs. last birthday) <b>73</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>Oct. 13, 1926</b>	9. Birthplace (State or Foreign Country) <b>Virginia</b>
Usual Residence of Decedent				
10a. State <b>Virginia</b>	10b. County <b>Accomack</b>	10c. City, Town or Location <b>Tangier</b>		10d. Inside City Limits <b>1 Yes 2 No</b>
10e. Street and Number <b>13631 Main Ridge Road</b>		10f. Zip Code <b>23440</b>		10g. Citizen of What Country? <b>USA</b>
11. Marital Status <b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 Yes 2 No World War II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 Yes 2 No Specify:</b>
14. Race - American Indian, Black, White, etc. <b>Specify: White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11 (graduate)</b> College (1-4 or 5+) <b>0</b>		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Waterman</b>		16b. Kind of Business/Industry <b>Seafood</b>		
17. Father's Name (First, Middle, Last) <b>Weldon M. Wheatley</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Castella Dise</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Henrietta Wheatley (wife)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13631 Main Ridge Road - PO Box 181-Tangier, VA23440</b>		
20a. Method of Disposition <b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Swain Memorial Cemetery</b>		20c. Location - City or Town, State <b>8/9/00 Tangier, VA</b>
21. Signature of Funeral Service Licensee <b>Robert H. Bradshaw</b>		22. Name and Address of Facility <b>Bradshaw &amp; Sons Funeral Home 306 W. Main St. - Crisfield, MD 21817</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				
Immediate Cause (Final disease or condition resulting in death) <b>C1 C2 fracture with subluxation with complication</b>				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Sepsis Pneumonia</b>				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Sepsis Pneumonia</b>				
23b. Did tobacco use contribute to the cause of death? <b>1 Yes 2 No 3 Probably 4 Unknown</b>				
24a. Was an autopsy performed? <b>1 Yes 2 No</b>				
24b. Were autopsy findings available prior to completion of cause of death? <b>1 Yes 2 No</b>				
25. Was case referred to medical examiner? <b>1 Yes 2 No</b>		26. Place of Death (Check only one) Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>		
27. Manner of Death <b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined</b>		28a. Date of Injury (Month, Day, Year) <b>July 4, 2000</b>		
28b. Time of Injury <b>4:00 AM</b>		28c. Injury at Work? <b>1 Yes 2 No</b>		
28d. Describe how injury occurred <b>Fell at home, Patient fracturing his neck</b>		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Home</b>		
28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>Tangier, Virginia 23440</b>		29a. Certifier (Check only one) <b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>		
29b. Signature and title of certifier <b>Salvador Sylvester DO</b>		29c. License number <b>H0055927</b>		29d. Date signed (Month, Day, Year) <b>August 6, 2000</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Salvador Sylvester, 3001 Hospital Drive, Cheverly, Maryland</b>				
31. Date filed (Month, Day, Year) <b>AUG 09 2000</b>		32. Registrar's Signature <b>Denise B. Sparks</b>		

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27511

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John C. C. Yuan					2. Date of Death Month Day Year August 13, 2000		3. Time of Death 1:30 am		
	4a. Facility Name (If not institution, give street and number) Manor Care Bethesda					4b. City, Town, or Location of Death Bethesda		4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 556-26-4479		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 90 Yrs.		8. Date of Birth (Month, Day, Year) July 23, 1910		9. Birthplace (State or Foreign Country) China	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Rockville			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 10500 Rockville Pike #1506				10f. Zip Code 20852-3353			10g. Citizen of What Country? United States		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Asian		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Economist			16b. Kind of Business/Industry International Monetary Fund			
	17. Father's Name (First, Middle, Last) K. W. Yuan					18. Mother's Name (First, Middle, Maiden Surname) H. C. Cheng				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Norma Yuan/ Wife					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10500 Rockville Pike #1506 Rockville, Maryland 20852				
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Montgomery Crematorium Inc.			Date August 16, 2000		20c. Location - City or Town, State Bethesda, Maryland	
	21. Signature of Funeral Service Licensee M00335					22. Name and Address of Facility Robert A. Humphrey Funeral Home/ Bethesda-Chevy Chase, Inc. Bethesda, Maryland 20814-3501				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Urosepsis Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dementia									
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No									
State Registrar	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)				
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier D. Scott Cohen M.D.					29c. License number MD D42051		29d. Date signed (Month, Day, Year) August 14, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D. Scott Cohen, M.D. 5454 Wisconsin Avenue #1125 Chevy Chase, Maryland 20815										
31. Date filed (Month, Day, Year) AUG 16 2000					32. Registrar's Signature Barbara B. Sparks					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show injury or other traumatic event, the Medical Examiner must be notified at 202-695-0000.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended Item 1, per M.E.

State of Maryland / Department of Health and Mental Hygiene

08/15/2000, Carroll County, wjl

Certificate of Death

Reg. No.

00 27512

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>DORIS FILOMENA ZIRALDO</b> <del>DORIS DOMINI ZIRALDO</del>				2. Date of Death Month Day Year <b>August 12, 2000</b>		3. Time of Death <b>10:20 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>30 Locust Street Apt. 704</b>				4b. City, Town, or Location of Death <b>Westminster</b>		4c. County of Death <b>Carroll</b>	
Funeral Director	5. Social Security Number <b>578-54-5943</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>71</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>March 21, 1929</b>	
	9. Birthplace (State or Foreign Country) <b>New York</b>		10a. State <b>Maryland</b>		10b. County <b>Carroll</b>		10c. City, Town or Location <b>Westminster</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number <b>30 Locust Street Apt. 704</b>			
	10f. Zip Code <b>21157</b>				10g. Citizen of What Country? <b>United States</b>			
To Be Completed by Physician/Medical Examiner	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Domestic</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Attilio Domini</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lena Agonita</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Fabrizio Ziraldo/son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1348 Western Chapel Road, New Windsor, MD 21776</b>			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Carroll Cremation</b>		Date <b>8/14</b>		20c. Location - City or Town, State <b>Hampstead, MD</b>	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Myers Funeral Home 91 Willis Street Westminster, MD 21157</b>					
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>ASCVD</b>				Approximate Interval Between Onset and Death <b>years</b>			
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. <b>Parkinsons Disease</b>				23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier 				29c. License number <b>00051924</b>		29d. Date signed (Month, Day, Year) <b>August 14, 2000</b>	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Herbert P. Henderson Jr. MD 295 Stoner Ave Suite 307 Westminster MD 21157</b>							
	31. Data filed (Month, Day, Year) <b>AUG 15 2000</b>				32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 00 27513

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) William Bawn		2. Date of Death Month August Day 30 Year 2000		3. Time of Death 13:10
	4a. Facility Name (If not Institution, give street and number) Johns Hopkins Hospital		4b. City, Town, or Location of Death Baltimore city		4c. County of Death N/A
Funeral Director	5. Social Security Number N/A	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 75 Yrs.	8. Date of Birth (Month, Day, Year) NOV 9, 1924	9. Birthplace (State or Foreign Country) England
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State Bermuda	10b. County N/A	10c. City, Town or Location Southampton SN.02		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	10e. Street and Number Birdsong #9 Orchard Drive		10f. Zip Code N/A		10g. Citizen of What Country? Bermuda
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Photographer
	16b. Kind of Business/Industry Hotel Industry		17. Father's Name (First, Middle, Last) Thomas Bawn		18. Mother's Name (First, Middle, Maiden Surname) UNK. King
	19a. Informant's Name/Relationship (Type, Print) Susan Margaret Bawn/Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Birdsong #9 Orchard Drive, Southampton SN.02 Bermuda		
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc. 8/31/00		20c. Location - City or Town, State Baltimore, MD
	21. Signature of Funeral Service Licensee Edward A. Gregorchik		22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Esophageal Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Approximate Interval Between Onset and Death 3 months				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined					
28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 29c. License number Res-000 29d. Date signed (Month, Day, Year) August 30, 2000					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jianxin Ma, Johns Hopkins Hospital, 600 North Wolfe Street, Tower 110, Doctors Lounge, Baltimore, MD 21287					
31. Date filed (Month, Day, Year) AUG 31 2000 32. Registrar's Signature B. Sparks					

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland Department of Health and Mental Hygiene

00 27514

AMEND ITEM: #9 PER F.H. G787 9-8-00 Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ROBERT BUSSEY</b>		2. Date of Death Month <b>AUGUST</b> Day <b>29</b> Year <b>2000</b>		3. Time of Death <b>11:42 am</b>
	4a. Facility Name (If not institution, give street and number) <b>BAYVIEW MEDICAL CENTER</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>
Funeral Director	5. Social Security Number <b>216-28-6872</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>73</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>FEB. 27, 1927</b>		9. Birthplace (State or Foreign Country) <b>SEVERN MD</b>		
Usual Residence of Decedent					
10a. State <b>MARYLAND</b>		10b. County <b>ANNE ARUNDEL</b>		10c. City, Town or Location <b>SEVERN</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <b>1708 CROSSBAY COURT</b>			10f. Zip Code <b>21144</b>		10g. Citizen of What Country? <b>U.S.A.</b>
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>1945-</b> If Yes, Give Year or Dates: <b>?</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>INSPECTOR</b>		16b. Kind of Business/Industry <b>WESTINGHOUSE</b>	
17. Father's Name (First, Middle, Last) <b>WILLIAM OTTO BUSSEY</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>IDA BLUNT</b>		
19a. Informant's Name/Relationship (Type, Print) <b>OLA M. BUSSEY (WIFE)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1708 CROSSBAY COURT, SEVERN, MARYLAND 21144</b>		
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GLEN HAVEN MEMORIAL PARK 2000</b>		20c. Location - City or Town, State <b>GLEN BURNIE, MD.</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		a. <b>SUBDURAL HEMATOMA</b> Due to (or as a consequence of):			Approximate Interval Between Onset and Death <b>18 HOURS</b>
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. <b>RENAL FAILURE</b> Due to (or as a consequence of):			<b>3 WEEKS</b>
		c. <b>THROMBOCYTOPENIA</b> Due to (or as a consequence of):			<b>YEARS</b>
		d. <b>POLYCYTHEMIA VERA</b> Due to (or as a consequence of):			<b>YEARS</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>Dr. Prowell, MD Resident Physician</b>		29c. License number <b>RES-000</b>		29d. Date signed (Month, Day, Year) <b>August 29, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>T. PROWELL, MD JOHNS HOPKINS 600 NORTH WOLFE ST BALTIMORE, MD 21287</b>					
31. Date filed (Month, Day, Year) <b>AUG 31 2000</b>		32. Registrar's Signature 			

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27515

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ERMA BEE FELT				2. Date of Death Month Day Year August 29 2000		3. Time of Death 2050 pm	
	4a. Facility Name (If not institution, give street and number) Northwest Hospital Center				4b. City, Town, or Location of Death Randallstown, MD.		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 213-05-7870		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 90 Yrs.		8. Date of Birth (Month, Day, Year) March 5, 1910	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Carroll		10c. City, Town or Location Sykesville	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 7309 Second Avenue		10f. Zip Code 21784		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Unknown		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Seamstress		16b. Kind of Business/Industry Sewing Factory			
	17. Father's Name (First, Middle, Last) John J. Evans				18. Mother's Name (First, Middle, Maiden Surname) Ruth Anne Whitcomb			
	19a. Informant's Name/Relationship (Type, Print) Sarah R. Miller / great-niece				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3200 Falls Road, Hampstead, Maryland 21074			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore National Cem.		20c. Date 9/1/2000		20d. Location - City or Town, State Baltimore, Maryland	
	21. Signature of Funeral Service Licensee Guante R Thomas				22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Sepsis Due to (or as a consequence of): b. Urinary tract infection Due to (or as a consequence of): c. Dehydration Due to (or as a consequence of): d. Fever							
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia Bilateral Blindness Anemia							
	23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier S. Sinding MD				29c. License number D30119		29d. Date signed (Month, Day, Year) 8/29/2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAHIDA SIDDIQI 6212 SYKESVILLE 21784								
31. Date filed (Month, Day, Year) AUG 31 2000		32. Registrar's Signature B. Sparks						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27516

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Rose Marie Brumel</b>				2. Date of Death Month Day Year <b>AUGUST 27, 2000</b>				3. Time of Death <b>5:20 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Saint Joseph Medical Center</b>				4b. City, Town, or Location of Death <b>Towson</b>				4c. County of Death <b>Baltimore</b>		
Funeral Director	5. Social Security Number <b>391-36-9072</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>60</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>April 25, 1940</b>		9. Birthplace (State or Foreign Country) <b>Wi.</b>		
	10a. State <b>Md.</b>				10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Timonium</b>				
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number <b>20 Arverne Ct.</b>				10f. Zip Code <b>21093</b>		
	10g. Citizen of What Country? <b>USA</b>				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		
	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>4</b>		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Teacher</b>				16b. Kind of Business/Industry <b>Elementary Education</b>				17. Father's Name (First, Middle, Last) <b>Joseph Herbert Skalitzky</b>		
	18. Mother's Name (First, Middle, Maiden Surname) <b>Bernadine Marie Haberman</b>				19a. Informant's Name/Relationship (Type, Print) <b>Mr. Eugene Brumel (Husband)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>20 Arverne Ct. Timonium, Md. 21093</b>		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Joseph Cemetery</b>				20c. Location - City or Town, State <b>9/1/00 Waterloo, Wi.</b>		
	21. Signature of Funeral Service Licensee <b>Jeffrey L. Gair</b>				22. Name and Address of Facility <b>Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204-2515</b>				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. <b>RESPIRATORY FAILURE</b>		
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>METASTATIC CARCINOMA</b>				23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				24a. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year) <b>8-28-2000</b>				28b. Time of Injury <b>M</b>		
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)			
Physician /Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <b>Richard L. Linthicum</b>				29c. License number <b>D31826</b>		
	29d. Date signed (Month, Day, Year) <b>8-28-2000</b>				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>RICHARD L. LINTHICUM, M.D. 7601 OSLER DRIVE, TOWSON, MARYLAND 21204</b>				31. Date filed (Month, Day, Year) <b>AUG 31 2000</b>		
32. Registrar's Signature <b>[Signature]</b>				33. State Registrar <b>[Signature]</b>				34. State Registrar <b>[Signature]</b>		35. State Registrar <b>[Signature]</b>	

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27517

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARGARET MARY BILLING

2. Date of Death

Month Day Year  
August 24 2000

3. Time of Death

10:25 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Mariner of Glen Burnie

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

5. Social Security Number

212-26-8125

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
March 10, 1929

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore City

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3120 Foster Avenue

10f. Zip Code

21224

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Credit Manager

16b. Kind of Business/Industry

Brewery

17. Father's Name (First, Middle, Last)

Harvey B. Reese

18. Mother's Name (First, Middle, Maiden Surname)

Anna Zipfel

19a. Informant's Name/Relationship (Type, Print)

Louis U. Billing - Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3120 Foster Avenue Baltimore, Maryland 21224

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Sacred Heart of Jesus Cem 8/28

Date

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

*Elizabeth Schinski*

22. Name and Address of Facility

Charles S. Zeiler & Son, Inc.  
6224 Eastern Avenue Baltimore, Maryland 2122423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)e. *Alzheimer's Type Dementia* Years

b. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)29b. Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Attending Physician*  
*MD*

29c. License number

D44973

29d. Date signed (Month, Day, Year)

Aug 25<sup>th</sup> 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GURMEET S. SAHNI MD  
329 HOSPITAL DRIVE GLEN BURNIE BMD 21061

31. Date filed (Month, Day, Year)

AUG 31 2000

32. Registrar's Signature

*Benjamin A. Sparks*State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27518

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOHN FRANCIS CADDEN Jr.				2. Date of Death Month Day Year AUGUST 28, 2000		3. Time of Death 6:22P.M.		
	4a. Facility Name (If not institution, give street and number) 1101 ST. PAUL STREET				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A		
Funeral Director	5. Social Security Number 219-28-1616		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 66 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 13, 1933		
	10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 1101 St. Paul St.				10f. Zip Code 21202		10g. Citizen of What Country? U.S.A.			
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PHYSICIAN		16b. Kind of Business/Industry MEDICAL			
17. Father's Name (First, Middle, Last) John Francis Cadden Sr.				18. Mother's Name (First, Middle, Maiden Surname) Mildred Louise City					
19a. Informant's Name/Relationship (Type, Print) John Francis Cadden Jr. (Self)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1101 ST. Paul St. Baltimore, Maryland 21202					
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify): Entombment			20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Mausoleum		20c. Location - City or Town, State Timonium, Maryland		20d. Date 9/2/00		
21. Signature of Funeral Service Licensee Robert M. Kratz				22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc. 6500 York Rd. Baltimore, Md. 21212					
23a. Part I. Enter the disease, or complications that caused death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Contact Gunshot Wounds of Head and Left Chest Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
				24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
				24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) SCENE					
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year) Found 8-28-00		28b. Time of Injury Found 1:45P		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
				28d. Describe how injury occurred self inflicted gunshot wound		28e. Location (Street and Number or Rural Route Number, City or Town, State) 1101 St. Paul Street Baltimore, MD			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Dennis J. Chute		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) AUGUST 29, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J. Chute				111 Penn Street, Baltimore, Maryland 21201					
31. Date filed (Month, Day, Year) AUG 31 2000				32. Registrar's Signature B. Sparks					

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#29d per PhyG786 8/31/2000 EW

## Certificate of Death

Reg. No.

00 27519

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>KENNETH JOSEPH CAVANAUGH</b>				2. Date of Death Month Day Year <b>AUGUST 28 2000</b>		3. Time of Death <b>515PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>10520 MARIOTTSVILLE ROAD</b>				4b. City, Town, or Location of Death <b>RANDALLSTOWN</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>213-84-0629</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>37</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Apr 10, 1963</b>	
	9. Birthplace (State or Foreign Country) <b>New Jersey</b>		10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Randallstown</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>4400 Windy Hill Rd</b>		10f. Zip Code <b>21133</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HVAC Technician</b>		16b. Kind of Business/Industry <b>Heating &amp; Air Conditioning</b>				
17. Father's Name (First, Middle, Last) <b>Peter J. Cavanaugh</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Evelyn Andes</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Ms. Evelyn Cavanaugh</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4872 Ilchester Rd. Ellicott City, Maryland 21043</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>All County Cremation Services, Inc.</b>		Date <b>08/31/00</b>		20c. Location - City or Town, State <b>Sykesville, Maryland</b>		
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043</b>				
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  a. <b>GUNSHOT WOUND TO HEAD</b> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b>								
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>AUGUST 28 2000</b>		28b. Time of Injury <b>11 A M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred <b>SELF INFLICTED</b>		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>FARM 10520 MARIOTTSVILLE ROAD</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>(RANDALLSTOWN MARYLAND)</b>				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <b>21171</b>		29d. Date signed (Month, Day, Year) <b>AUGUST 18, 2000</b>		
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) <b>E. R. WILLIAMSON 405 FREDERICK ROAD CATONSVILLE 21228 MARYLAND</b>								
31. Date filed (Month, Day, Year) <b>AUG 31 2000</b>				32. Registrar's Signature <i>[Signature]</i>				

*Handwritten signature*

(A)



Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "Natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 66760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Richard W. Coleman</b>					2. Date of Death Month <b>August</b> Day <b>29</b> Year <b>2000</b>			3. Time of Death <b>06:40 A.M.</b>			
	4a. Facility Name (If not Institution, give street and number) <b>Route 50 &amp; Rockwalkin Road</b>					4b. City, Town, or Location of Death <b>Hebron</b>			4c. County of Death <b>Wicomico</b>			
Funeral Director	5. Social Security Number <b>217-70-4280</b>		6. Sex <b>1 M 2 F</b>		7. Age (In yrs. last birthday) <b>30</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>July 28, 1970</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>			
	Usual Residence of Decedent					10a. State <b>Maryland</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Pasadena</b>		
10d. Inside City Limits <b>1 Yes 2 No</b>					10e. Street and Number <b>8067 Wolsey Court</b>			10f. Zip Code <b>21122</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <b>1 Never Married 2 Married</b> <b>3 Widowed 4 Divorced</b>			12. Was Decedent Ever in U.S. Armed Forces? <b>1 Yes 2 No</b> If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 Yes 2 No</b> Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>1</b>					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Contractor</b>			16b. Kind of Business/Industry <b>Roofing Company</b>				
17. Father's Name (First, Middle, Last) <b>Richard W. Coleman, Sr.</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Kathy L. Camden</b>							
19a. Informant's Name/Relationship (Type, Print) <b>Kathy L. Camden (Mother)</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8067 Wolsey Court Pasadena, Maryland 21122</b>							
20a. Method of Disposition <b>1 Burial 2 Cremation 3 Removal from State</b> <b>4 Donation 5 Other (Specify)</b>					20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Greenmount Crematory</b>			20c. Location - City or Town, State <b>8/31/00 Baltimore, Maryland</b>				
21. Signature of Funeral Service Licenses 					22. Name and Address of Facility <b>McCully-Polyniak Funeral Home, P.A.</b> <b>3204 Mountain Road Pasadena, Maryland 21122</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Multiple injuries</b> Dua to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Dua to (or as a consequence of):</b> <b>c. Dua to (or as a consequence of):</b> <b>d. Dua to (or as a consequence of):</b>											Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											23b. Did tobacco use contribute to the cause of death? <b>1 Yes 2 No 3 Probably 4 Unknown</b>	
											24a. Was an autopsy performed? <b>1 Yes 2 No</b>	
											24b. Were autopsy findings available prior to completion of cause of death? <b>1 Yes 2 No</b>	
25. Was case referred to medical examiner? <b>X Yes 2 No</b>					26. Place of Death (Check only one) Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify) SCENE</b>							
27. Manner of Death <b>1 Natural 2 Accident 3 Suicide 4 Homicide</b> <b>5 Pending investigation 6 Could not be determined</b>					28a. Date of Injury (Month, Day, Year) <b>8-29-00</b>		28b. Time of Injury <b>06:33 AM</b>		28c. Injury at Work? <b>1 Yes 2 No</b>		28d. Describe how injury occurred <b>MOTORCYCLE DRIVER, LOST CONTROL</b>	
					28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>ROADWAY</b>			28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>RT 50 WICOMICO CO, MD</b>				
29a. Certifier (Check only one) <b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>					29b. Signature and title of certifier 			29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>August 30, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Marysaw A. Koron 111 Penn Street, Baltimore, Maryland 21201</b>												
31. Date filed (Month, Day, Year) <b>Aug 31 2000</b>					32. Registrar's Signature 							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

0787 9-7-00 WR.

00 27521

AMEND ITEMS: #23 PART I, 27 PER MEO Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIAM NORMAN CLANTON			2. Date of Death Month Day Year August 25, 2000		3. Time of Death 2140 pm	
	4a. Facility Name (If not institution, give street and number) 1918 Taylor Avenue			4b. City, Town, or Location of Death Parkville		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 246-40-9381	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 71 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) AUG 13 1929	9. Birthplace (State or Foreign Country) NORTH CAROLINA
	Usual Residence of Decedent						
10a. State MARYLAND		10b. County BALTIMORE		10c. City, Town or Location PARKVILLE		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 1918 TAYLOR AVENUE				10f. Zip Code 21234		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (1-4or 5+) College			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MECHANICAL ENGINEER		16b. Kind of Business/Industry LAUNDRY		
17. Father's Name (First, Middle, Last) WILLIAM NORMAN CLANTON SR.				18. Mother's Name (First, Middle, Maiden Surname) VIOLA JARRELL			
19a. Informant's Name/Relationship (Type, Print) Rev. John L. Clanton/Brother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1918 Taylor Avenue, Parkville, Md., 21234			
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) Entombment		20b. Place of Disposition (Name of cemetery, crematory or other place) DULANEY VALLEY MEMORIAL		Date 8-31-00		20c. Location - City or Town, State DULANEY VALLEY, MD.	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 1206 W NORTH AVENUE			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  PNEUMONIA  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):							Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) at scene					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) August 26, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis Chute 111 Penn Street, Baltimore, Maryland 21201							
31. Date filed (Month, Day, Year) AUG 31 2000		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27522

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ABEL A. CAPLAN</b>		2. Date of Death Month Day Year <b>AUGUST 25, 2000</b>		3. Time of Death <b>2:10 PM</b>
	4a. Facility Name (If not institution, give street and number) <b>FUTURECARE CHERRYWOOD NURSING HOME</b>		4b. City, Town, or Location of Death <b>REISTERSTOWN</b>		4c. County of Death <b>BALTIMORE</b>
Funeral Director	5. Social Security Number <b>215-12-0203</b>	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>77</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>SEPT. 14, 1922</b>		9. Birthplace (State or Foreign Country) <b>MD</b>		
Usual Residence of Decedent					
10e. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>	
10f. Zip Code <b>21229</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
10e. Street and Number <b>1212 PINE HEIGHTS AVENUE</b>					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>2</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>JUVENILE COUNSELOR</b>		16b. Kind of Business/Industry <b>STATE OF MARYLAND</b>	
17. Father's Name (First, Middle, Last) <b>ISRAEL CAPLAN</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>GOLDA (UNKNOWN)</b>			
19a. Informant's Name/Relationship (Type, Print) <b>HOWARD S. CAPLAN / SON</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1212 PINE HEIGHTS AVENUE - BALTIMORE, MD 21229</b>			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>OHEB SHALOM MEMORIAL PARK</b>		20c. Location - City or Town, State <b>8/27/00 REISTERSTOWN, MD</b>	
21. Signature of Funeral Service Licensee <i>Scott M. Artley</i>		22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Parkinsons Disease</b>  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Dementia</b>  Due to (or as a consequence of):		Approximate Interval Between Onset and Death <b>6 yrs</b>			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Dementia</b>		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>M</b>		28b. Time of Injury <b>1</b> Yes 2 <input type="checkbox"/> No	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Robert J. Moss, MD</i>		29c. License number <b>032882</b>	
29d. Date signed (Month, Day, Year) <b>8/26/2000</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Robert Moss 114 Business Center Drive Reisterstown, MD 21126</b>					
31. Date filed (Month, Day, Year) <b>AUG 31 2000</b>		32. Registrar's Signature <i>James B. Sparks</i>			

Baltimore, Maryland 21215-0020

perml. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended Item#5,8 per FHG787 9/12/2000 EW

State of Maryland / Department of Health and Mental Hygiene

00 27523

AMENDED ITEM #7 PER FH G786 8/31/00 AH

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Elsie</b>		2. Date of Death Month <b>August</b> Day <b>24</b> Year <b>2000</b>		3. Time of Death <b>20:45</b>
	4a. Facility Name (If not institution, give street and number) <b>THE JOHNS HOPKINS HOSPITAL</b>		4b. City, Town, or Location of Death <b>Baltimore City</b>		4c. County of Death <b>N/A</b>
Funeral Director	5. Social Security Number <b>217-20-2689</b>	6. Sex <b>1</b> M <b>2</b> F	7. Age (In yrs. last birthday) <b>73</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth <b>10-4-26</b> (Month, Day, Year)		9. Birthplace (State or Foreign Country) <b>VA.</b>		
Usual Residence of Decedent					
10a. State <b>MD.</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>	
10d. Inside City Limits <b>1</b> Yes <b>2</b> No					
10e. Street and Number <b>2327 IVY AVE.</b>			10f. Zip Code <b>21214</b>		10g. Citizen of What Country? <b>USA</b>
11. Marital Status <b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> Yes <b>2</b> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> Yes <b>2</b> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>-12-</b> College (1-4 or 5+) <b>-8-</b>		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>EDUCATOR</b>		16b. Kind of Business/Industry <b>EDUCATION</b>	
17. Father's Name (First, Middle, Last) <b>GEORGE H. BANKS</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>VICTORIA ARTIS</b>		
19a. Informant's Name/Relationship (Type, Print) <b>SAMUEL A. COSTEN (HUSBAND)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2327 IVY AVE. BALTIMORE, MARYLAND 21214</b>		
20a. Method of Disposition <b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>DULANEY VALLEY MEMORIAL</b>		20c. Location - City or Town, State <b>8-29-2000 TIMONIUM, MARYLAND</b>	
21. Signature of Funeral Service Licensee <i>Jonathan D. Huzar</i>		22. Name and Address of Facility <b>PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		a. <b>Sepsis</b> Due to (or as a consequence of):		Approximate Interval Between Onset and Death <b>two days</b>	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. _____ Due to (or as a consequence of):			
		c. _____ Due to (or as a consequence of):			
		d. _____ Due to (or as a consequence of):			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Acute Respiratory Distress Syndrome</b>					
23b. Did tobacco use contribute to the cause of death? <b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown					
24a. Was an autopsy performed? <b>1</b> Yes <b>2</b> No					
24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> Yes <b>2</b> No					
25. Was case referred to medical examiner? <b>1</b> Yes <b>2</b> No		26. Place of Death (Check only one) Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>8</b> Other (Specify)			
27. Manner of Death <b>1</b> Natural <b>5</b> Pending Investigation <b>2</b> Accident <b>6</b> Could not be determined <b>3</b> Suicide <b>4</b> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
		28c. Injury at Work? <b>1</b> Yes <b>2</b> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <i>Eric Yang</i>		29c. License number <b>RA5-000</b>		29d. Date signed (Month, Day, Year) <b>August 24, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Eric Yang, MD 600 North Wolfe Street, Baltimore Maryland 21287</b>					
31. Date filed (Month, Day, Year) <b>AUG 31 2000</b>		32. Registrar's Signature <i>Benjamin B. Sparks</i>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

2. 08. 1944. 10. 10. 1944.

2. 08. 1944.

1. 08. 1944. 10. 10. 1944.

1. 08. 1944.

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1. 08. 1944.

1. 08. 1944. 10. 10. 1944.

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27524

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

June Culley

2. Date of Death

August 21 2000

3. Time of Death

0920

4a. Facility Name (If not institution, give street and number)

Fallston General Hospital

4b. City, Town, or Location of Death

Fallston

4c. County of Death

Harford

Funeral  
Director

5. Social Security Number

404-48-6465

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

67

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 22, 1933

9. Birthplace (State or Foreign Country)

Kentucky

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Joppatowne

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

414 Breslin Road

10f. Zip Code

21085

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clinic Director

16b. Kind of Business/Industry

Veterans Hospital

17. Father's Name (First, Middle, Last)

Wilbur W. Culley

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Dodge

19a. Informant's Name/Relationship (Type, Print)

Hardy Funeral Home

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10907 Dixie Highway Louisville Kentucky 40272

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bethany Memorial Cem.

Date

8/26/00

20c. Location - City or Town, State

Louisville, Kentucky

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

John C. Miller Inc.

6415 Belair Road Baltimore, Maryland 21206

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or organ failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Due to (or as a consequence of):

Sepsis

Approximate Interval Between Onset and Death

1 day

b.

Due to (or as a consequence of):

Skin Necrosis

3 weeks

c.

Due to (or as a consequence of):

Diabetes Mellitus

30 years

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atherosclerotic Cardiovascular Disease

Chronic Renal Failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

29c. License number

H39022

29d. Date signed (Month, Day, Year)

August 21, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PETER LORESTI, MD, FACP 1508 Business Center Way Edgewood MD

31. Date filed (Month, Day, Year)

AUG 31 2000

32. Registrar's Signature

James A. Sparks

State  
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 37 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

JUNE CULLEY

PA14



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27525

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Eleth Roy Carter</u>				2. Date of Death Month <u>August</u> Day <u>27</u> Year <u>2000</u>		3. Time of Death <u>6:00 P.M.</u>	
	4a. Facility Name (If not institution, give street and number) <u>VAMHCS FORT HOWARD DIVISION</u>				4b. City, Town, or Location of Death <u>FORT HOWARD</u>		4c. County of Death <u>BALTIMORE</u>	
Funeral Director	5. Social Security Number <u>226-28-8482</u>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <u>74</u> Yrs.		8. Date of Birth Month <u>April</u> Day <u>30</u> Year <u>1926</u>	
	9. Birthplace (State or Foreign Country) <u>Virginia</u>		10a. State <u>Maryland</u>		10b. County <u>N/A</u>		10c. City, Town or Location <u>Baltimore</u>	
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	11. Merital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <u>WWII</u>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
	14. Race - American Indian, Black, White, etc. Specify: <u>Black</u>				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>0</u> College (1-4 or 5+) <u>0</u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Steel Worker</u>	
	16b. Kind of Business/Industry <u>Bethlehem Steel Co.</u>				17. Father's Name (First, Middle, Last) <u>Pleasant Carter</u>		18. Mother's Name (First, Middle, Maiden Surname) <u>Jennie Mayo</u>	
	19a. Informant's Name/Relationship (Type, Print) (Wife) <u>Mrs. Lillian Carter</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>800 Wilbert Ave, Balto, Md. 21212</u>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Garrison Forest</u>		20c. Location - City or Town, State <u>9/1/2000 Owings Mills, Md.</u>	
	21. Signature of Funeral Service Licensee <u>Joseph L. Russ</u>				22. Name and Address of Facility <u>Joseph L. Russ Funeral Home</u> <u>2222 W. North Ave. Balto. Md. 21216</u>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Physician /Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)			
	28b. Time of Injury <u>M</u>				28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier <u>[Signature]</u>				29c. License number <u>05237</u>		29d. Date signed (Month, Day, Year) <u>August 27, 2000</u>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>SURESH SHANDELYA, M.D. 9600 NORTH POINT ROAD, FORT HOWARD, MD 21052</u>							
	State Registrar	31. Date filed (Month, Day, Year) <u>AUG 31 2000</u>				32. Registrar's Signature <u>[Signature]</u>		

CARTER, ELETHER R.  
Baltimore, Maryland 21215-0020

perm. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27526

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Louis, D'Ambrogi

2. Date of Death

08 28 2006

3. Time of Death

11:55/A

4a. Facility Name (If not institution, give street and number)

Noble House

4b. City, Town, or Location of Death

Balto, md

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

220-07-1593

6. Sex

XX M 2 F

7. Age (In yrs. last birthday)

82

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

December 2, 1917

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore  
2327 North Charles Street

10d. Inside City Limits

1 Yes 2 No  
XX

10e. Street and Number

2327 North Charles Street

10f. Zip Code

21218

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married  
3 Widowed 4 Divorced  
XX

12. Was Decedent Ever in U.S.

Armed Forces?  
1 Yes 2 No  
If Yes, Give  
Year or Dates: XX13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 Yes 2 No  
XX Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Lithographer

16b. Kind of Business/Industry

Bottling

17. Father's Name (First, Middle, Last)

Attilio D'Ambrogi

18. Mother's Name (First, Middle, Maiden Surname)

Lena Unk

19a. Informant's Name/Relationship (Type, Print)

Arthur Drager

Lawyer

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10 North Calvert Street Baltimore, Maryland 21202

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State  
4 Donation 5 Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Greenmount Cemetery

Date

8/31/00

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

*Bernis Hayden Kenarko*

22. Name and Address of Facility

Mitchell-Wiedefeld Funeral Home Inc  
6500 York Road Baltimore, Maryland 2121223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Acute Myocardial Infarction  
Due to (or as a consequence of):Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d.Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Alzheimer's Disease

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy  
performed?

1 Yes 2 No

24b. Were autopsy findings  
available prior to  
completion of cause  
of death?

1 Yes 2 No

25. Was case referred to medical  
examiner?  
1 Yes 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

Other:

26. Place of Death (Check only one)

4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 5 Pending  
2 Accident 6 investigation  
3 Suicide 6 Could not be  
4 Homicide 6 determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 Yes 2 No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29e. Certifier  
(Check only  
one)

1

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

*Bernis Hayden Kenarko MD*

29c. License number

D16619

29d. Date signed (Month, Day, Year)

August 28, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2327 N. CHARLES ST. BALTIMORE, MD. 21218

State  
Registrar

31. Date filed (Month, Day, Year)

AUG 31 2000

32. Registrar's Signature

*Bernis Hayden Kenarko*

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 25a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
2025.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

08 28 2000 12:30  
Date, time

10000 10000  
10000 10000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27527

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Gloria C. Damien				2. Date of Death Month Day Year AUGUST 26, 2000				3. Time of Death 2101	
	4a. Facility Name (If not institution, give street and number) ST. AGNES HEALTHCARE 900 CATON AVENUE				4b. City, Town, or Location of Death BALTIMORE				4c. County of Death N/A	
Funeral Director	5. Social Security Number 097-46-1167		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (in yrs. last birthday) 84 Yrs.		8. Date of Birth (Month, Day, Year) MAR 22, 1916		9. Birthplace (State or Foreign Country) Cuba	
	Usual Residence of Decedent									
10a. State New York		10b. County West Chester		10c. City, Town or Location Mammaroneck				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 320 Richbell Road				10f. Zip Code 10543		10g. Citizen of What Country? USA				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No Specify: Cuban			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Dentist			16b. Kind of Business/Industry Self Employed			
17. Father's Name (First, Middle, Last) Francisco Cortes					18. Mother's Name (First, Middle, Maiden Surname) Anuncia Gonzalez					
19a. Informant's Name/Relationship (Type, Print) Alfredo Damien/Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 320 Richbell Rd. Mammaroneck, NY 10543						
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory Inc.		Date 8-30-00		20c. Location - City or Town, State Baltimore, MD		
21. Signature of Funeral Service Licensee Thomas Gregor				22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) GASTRO INTESTINAL BLEEDING Due to (or as a consequence of): BOWEL OBSTRUCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Approximate Interval Between Onset and Death 2 hours										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier Charles Curtis MD				29c. License number D0051865		29d. Date signed (Month, Day, Year) AUGUST 26, 2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHARLES CURTIS BALTIMORE, MD ST AGNES HOSPITAL										
31. Date filed (Month, Day, Year) AUG 31 2000		32. Registrar's Signature Sparks								

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

00 27528

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) VIOLET MAE EBB			2. Date of Death Month Day Year August 27 2000		3. Time of Death 5:05pm	
	4a. Facility Name (If not institution, give street and number) GENESIS ELDERCARE-CATONSVILLE COMMONS			4b. City, Town, or Location of Death CATONSVILLE		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 218-30-5684	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 95 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) FEB 28 1905	9. Birthplace (State or Foreign Country) MARYLAND
	Usual Residence of Decedent						
10a. State MARYLAND		10b. County BALTIMORE		10c. City, Town or Location CATONSVILLE		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 336 MELVIN AVENUE APT A				10f. Zip Code 21228		10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th grade			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DOMESTIC		16b. Kind of Business/Industry HOME CARE		
17. Father's Name (First, Middle, Last) JAMES DORSEY			18. Mother's Name (First, Middle, Maiden Surname) LULA CLIFFORD				
19a. Informant's Name/Relationship (Type, Print) Catherine E. Wise/Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 336 Melvin Avenue Apt A, Baltimore, Maryland 21228				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) WESTERN STAR CEMETERY		20c. Location - City or Town, State 8-31-00 BALTIMORE, MARYLAND		
21. Signature of Funeral Service Licensee <i>[Signature]</i>			22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 1206 W NORTH AVENUE				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  a. <u>Urosepsis</u> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____							Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>End Stage Alzheimer's Dementia</u> <u>Hypertension</u>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
			28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier <i>[Signature]</i> M.D.			29c. License number D52671			29d. Date signed (Month, Day, Year) August 29, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shalini Tewari M.D. Suite 300 Pikesville, MD 21208							
31. Date filed (Month, Day, Year) AUG 31 2000			32. Registrar's Signature <i>[Signature]</i>				

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State of Maryland / Department of Health and Mental Hygiene

00 27529

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) PATRICK HENRY EGAN				2. Date of Death Month Day Year AUGUST 26 2000		3. Time of Death 3:44PM	
	4a. Facility Name (If not institution, give street and number) GREATER BALTIMORE MEDICAL CENTER				4b. City, Town, or Location of Death TOWSON		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 197-10-8977		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 88 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 4, 1912	
	9. Birthplace (State or Foreign Country) Pa.		10a. State Md.		10b. County Baltimore		10c. City, Town or Location Timonium	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 1909 Pot Spring Rd.		10f. Zip Code 21093		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Owner		16b. Kind of Business/Industry Cargo Securing		17. Father's Name (First, Middle, Last) John Eagan	
	18. Mother's Name (First, Middle, Maiden Surname) Jessie Carver		19a. Informant's Name/Relationship (Type, Print) Mrs. Helen M Egan/wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1909 Pot Spring Rd. Timonium, md. 21093		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) Entombment	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee		22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CONGESTIVE HEART FAILURE Due to (or as a consequence of): b. ANEMIA Due to (or as a consequence of): c. PROSTATE CANCER Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death 6 YRS 5 YRS 4 YRS	
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	
	28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier -ATTENDING M.D.		29c. License number D0025538		29d. Date signed (Month, Day, Year) 8/28/00	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peter P. Stamas, M.D. 6565 N. Charles St #402 Balto. MD 21204		31. Date filed (Month, Day, Year) AUG 31 2000		32. Registrar's Signature Benita B Sparks		State Registrar	

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State of Maryland / Department of Health and Mental Hygiene

00 27530

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Phyllis Ann Fava				2. Date of Death Month Day Year August 24 2000		3. Time of Death 14:45
	4a. Facility Name (If not institution, give street and number) Franklin Square Hospital Center				4b. City, Town, or Location of Death Rosedale		4c. County of Death Baltimore
Funeral Director	5. Social Security Number 215-03-2255	8. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	6. Date of Birth (Month, Day, Year) 01 31 1912	9. Birthplace (State or Foreign Country) MD
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State Md	10b. County Baltimore	10c. City, Town or Location Perry Hall			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 8820 Walther Boulevard			10f. Zip Code 21234		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Thomas Rizzo			18. Mother's Name (First, Middle, Maiden Surname) Frances (unknown)			
	19a. Informant's Name/Relationship (Type, Print) Frank T. Fava/ Son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12122 South Piney Point Rd, Bishopsville, Md 21813			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Mem Gard		Date 08 28	20c. Location - City or Town, State Baltimore, Maryland	
	21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility Sterling-Ashton-Schwab Funeral Home, Inc 736 Edmondson Avenue, Balto, Md. 21228				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Sepsis Due to (or as a consequence of): b. Stool Impaction Due to (or as a consequence of): c. Urinary Tract Infection Due to (or as a consequence of): d. Renal Failure						Approximate Interval Between Onset and Death 4 days 10 days 1 week 1 week
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)
Medical Certification: To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) M		28b. Time of Injury 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28c. Describe how injury occurred
	28d. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28e. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
	29b. Signature and title of certifier <i>[Signature]</i>		29c. License number RD 191841		29d. Date signed (Month, Day, Year) August 24, 2000		
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Tran 9000 Franklin Square Drive, Baltimore, MD. 21237						
	31. Date filed (Month, Day, Year) AUG 31 2000		32. Registrar's Signature <i>[Signature]</i>				

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

00 27531

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EDWIN FILLER				2. Date of Death Month Day Year Aug. 27 2000		3. Time of Death 2:40AM	
	4a. Facility Name (If not institution, give street and number) HOWARD COUNTY GENERAL HOSPITAL				4b. City, Town, or Location of Death COLUMBIA		4c. County of Death HOWARD	
Funeral Director	5. Social Security Number 218-05-0479	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 86	8. Date of Birth Month Day Year MAY 17, 1914	9. Birthplace (State or Foreign Country) Maryland			
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland	10b. County Howard	10c. City, Town or Location Columbia		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number 6336 Cedar Lane Apt #349			10f. Zip Code 21044		10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 1941- If Yes, Give Year or Dates: 1944		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Judge		16b. Kind of Business/Industry Federal Government			
	17. Father's Name (First, Middle, Last) John H. Filler				18. Mother's Name (First, Middle, Maiden Surname) Annie Elizabeth Stawlings			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mary B. Filler/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6336 Cedar La. Apt #349 Columbia, MD 21044			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory Inc.		20c. Location - City or Town, State 8-30-00 Baltimore, MD			
	21. Signature of Funeral Service Licensee Thomas Gregor		22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Respiratory failure Due to (or as a consequence of): End stage chronic obstructive pulmonary disease Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Approximate Interval Between Onset and Death days							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Acute bronchitis, cor pulmonale, azotemia, malnutrition, hypertension, cerebrovascular accident							
State Registrar	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
			28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred			
					28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier MD, FCCP				29c. License number D36845		29d. Date signed (Month, Day, Year) Aug. 27, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAI-CHI NGUYEN, MD, FCCP 7350 Grace Drive, Columbia, MD 21044								
31. Date filed (Month, Day, Year) AUG 31 2000				32. Registrar's Signature B. Sparks				





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27532

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARY N. FRANKE				2. Date of Death Month Day Year August 24, 2000		3. Time of Death 7:35 PM	
	4a. Facility Name (If not institution, give street and number) Lorien Nursing and Rehabilitation Center				4b. City, Town, or Location of Death Columbia		4c. County of Death Howard	
Funeral Director	5. Social Security Number 216-10-3684		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 92 Yrs.		8. Date of Birth (Month, Day, Year) March 2, 1908	
	9. Birthplace (State or Foreign Country) MARYLAND		10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore City	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				10e. Street and Number 5831 Belair Road		10f. Zip Code 21206	
	10g. Citizen of What Country? U.S.A.				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary				16b. Kind of Business/Industry Lucas		17. Father's Name (First, Middle, Last) Harry C. Henderson	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) Maggie V. Keagle				19a. Informant's Name/Relationship (Type, Print) Nancy Affeldt - Niece		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10841 Harmel Drive Columbia, Maryland 21044	
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens of Faith Cemetery		20c. Location - City or Town, State 8/28/00 Baltimore, Maryland	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>Elizabeth A. Schneck</i>				22. Name and Address of Facility John C. Miller, Inc. 6415 Belair Road Baltimore, Maryland 21206			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Dementia</i> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier <i>Peter C. Miller</i>		29c. License number D37777		29d. Date signed (Month, Day, Year) 8/25/00		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Peter C. Miller</i> 21000 North Dr. Columbia MD 21045	
	31. Date filed (Month, Day, Year) AUG 31 2000		32. Registrar's Signature <i>Peter C. Miller</i>		33. Date of Death (Month, Day, Year) AUG 24 2000			

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State of Maryland / Department of Health and Mental Hygiene 00 27533  
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) OSCAR KIRK GRADY				2. Date of Death Month Day Year AUGUST 26 2000		3. Time of Death 7:35 PM				
	4a. Facility Name (If not institution, give street and number) ROUTE 100 WESTBOUND AT SNOWDEN RIVER PKWY.				4b. City, Town, or Location of Death COLUMBIA		4c. County of Death HOWARD				
Funeral Director	5. Social Security Number 411-21-1615		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 35 Yrs.		8. Date of Birth (Month, Day, Year) FEB 9 1965		9. Birthplace (State or Foreign Country) TENNESSEE		
	Usual Residence of Decedent 10a. State DELAWARE 10b. County NEW CASTLE 10c. City, Town or Location N/A 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 12 GRAYBRIDGE DRIVE				10f. Zip Code 19810		10g. Citizen of What Country? U.S.A.
To Be Completed by Funeral Director		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK			
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade Collega (1-4or 5+) 1-4or 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LIFT OPERATOR		16b. Kind of Business/Industry CONSTRUCTION					
To Be Completed by Physician/Medical Examiner		17. Father's Name (First, Middle, Last) unknown				18. Mother's Name (First, Middle, Maiden Surname) JENNIE RUTH BRISTOL					
		19a. Informant's Name/Relationship (Type, Print) Tanya Grady/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12 Graybridge Drive, New Castle, Delaware 19810					
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) GRACELAWN MEMORIAL PARK		Date 9-1-00		20c. Location - City or Town, State NEW CASTLE, DELAWARE			
		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 1206 W NORTH AVENUE							
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  a. Multiple Injuries Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.								Approximate Interval Between Onset and Death	
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  24a. Was an autopsy performed? Yes 2 <input type="checkbox"/> No  24b. Were autopsy findings available prior to completion of cause of death? Yes 2 <input type="checkbox"/> No									
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020		25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Scene							
		27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) F-26-00		28b. Time of Injury 730 P M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred motorcycle accident	
State Registrar		29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) AUGUST 27, 2000	
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J Chute 111 Penn Street, Baltimore, Maryland 21201				31. Date filed (Month, Day, Year) AUG 31 2000				32. Registrar's Signature 	

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Amended Item#5,15 per FHG787 9/12/2000 State of Maryland / Department of Health and Mental Hygiene 00 27534  
Amended item# 1 per ME G786 8-31-00 WJJ

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Tai'Jah Dallas Garrett</u>				2. Date of Death Month <u>08</u> Day <u>18</u> Year <u>2000</u>		3. Time of Death <u>5:24 pm</u>	
	4a. Facility Name (If not institution, give street and number) <u>Mercy Medical Center</u>				4b. City, Town, or Location of Death <u>Baltimore</u>		4c. County of Death <u>MD</u>	
Funeral Director	5. Social Security Number <u>None</u>		6. Sex <u>1</u> M <u>2</u> F	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <u>08/18/2000</u>	9. Birthplace (State or Foreign Country) <u>MD</u>
	Usual Residence of Decedent							
10a. State <u>Maryland</u>		10b. County <u>N/A</u>		10c. City, Town or Location <u>Baltimore</u>			10d. Inside City Limits <u>1</u> Yes <u>2</u> No	
10e. Street and Number <u>4223 SHELTON AVE 2nd floor</u>				10f. Zip Code <u>21206</u>		10g. Citizen of What Country? <u>USA</u>		
11. Marital Status <u>1</u> Never Married <u>2</u> Married <u>3</u> Widowed <u>4</u> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <u>1</u> Yes <u>2</u> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <u>1</u> Yes <u>2</u> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>Black</u>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>None</u> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Infant</u>		16b. Kind of Business/Industry		
17. Father's Name (First, Middle, Last) <u>DYRELL GARRETT</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>VITISHA Mc LAREN</u>				
19a. Informant's Name/Relationship (Type, Print) <u>VITISHA McLAREN / MOTHER</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>21206</u> <u>4223 SHELTON AVE 2nd fl. Baltimore, Maryland</u>				
20a. Method of Disposition <u>1</u> Burial <u>2</u> Cremation <u>3</u> Removal from State <u>4</u> Donation <u>5</u> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>WOODLAWN Cemetery</u>		Date <u>8/24/2000</u>		20c. Location - City or Town, State <u>WOODLAWN, Maryland</u>		
21. Signature of Funeral Service Licensee <u>[Signature]</u>				22. Name and Address of Facility <u>CHATHAM HARRIS FUNERAL HOME</u> <u>5240 REISTERSTOWN ROAD</u> <u>BALTIMORE, Maryland 21215</u>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <u>a. myocardial failure</u> Due to (or as a consequence of): <u>b. congenital hydrops</u> Due to (or as a consequence of): <u>c. twin-twin transfusion</u> Due to (or as a consequence of): <u>d.</u>								Approximate Interval Between Onset and Death <u>1 hr</u>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>right pneumothorax</u> <u>Respiratory Distress Syndrome</u>						23b. Did tobacco use contribute to the cause of death? <u>1</u> Yes <u>2</u> No <u>3</u> Probably <u>4</u> Unknown		
24a. Was an autopsy performed? <u>1</u> Yes <u>2</u> No		24b. Were autopsy findings available prior to completion of cause of death? <u>1</u> Yes <u>2</u> No						
25. Was case referred to medical examiner? <u>1</u> Yes <u>2</u> No		26. Place of Death (Check only one) Hospital: <u>1</u> Inpatient <u>2</u> ER/Outpatient <u>3</u> DOA Other: <u>4</u> Nursing Home <u>5</u> Residence <u>6</u> Other (Specify)						
27. Manner of Death <u>1</u> Natural <u>5</u> Pending investigation <u>2</u> Accident <u>6</u> Could not be determined <u>3</u> Suicide <u>4</u> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <u>1</u> Yes <u>2</u> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <u>1</u> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <u>2</u> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <u>Rose Marie Viscardi MD</u>		29c. License number <u>D33775</u>		29d. Date signed (Month, Day, Year) <u>08/18/2000</u>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Rose Marie Viscardi MD 22 S. Greene St., NW68, Baltimore, MD 21201</u>								
31. Date filed (Month, Day, Year) <u>AUG 31 2000</u>		32. Registrar's Signature <u>[Signature]</u>						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





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State of Maryland / Department of Health and Mental Hygiene

00 27535

Amended Item#24a per PHYG786 8/31/20000 EW

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>RAYMOND GRIFFITH</b>			2. Date of Death Month Day Year <b>August 17 2000</b>			3. Time of Death <b>4:30 AM</b>															
	4e. Facility Name (If not institution, give street and number) <b>The good Samaritan Hospital 5601 Loch Raven Blvd Baltimore</b>			4b. City, Town, or Location of Death <b>Baltimore</b>			4c. County of Death <b>Baltimore City</b>															
Funeral Director	5. Social Security Number <b>227-16-1189</b>		6. Sex <b>1 M 2 F</b>		7. Age (In yrs. last birthday) <b>78</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>May 31, 1922</b>		9. Birthplace (State or Foreign Country) <b>unk</b>													
	Usual Residence of Decedent																					
10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <b>1 Yes 2 No</b>														
10e. Street and Number <b>4001 Schroeder Avenue</b>				10f. Zip Code <b>21128</b>		10g. Citizen of What Country? <b>USA</b>																
11. Marital Status <b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>			12. Was Decedent Ever in U.S. Armed Forces? <b>1 Yes 2 No</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <b>1 Yes 2 No</b>			14. Race - American Indian, Black, White, etc. <b>white</b>														
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) unk</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>unk</b>			16b. Kind of Business/Industry <b>unk</b>															
17. Father's Name (First, Middle, Last) <b>unk</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>unk</b>																		
19a. Informant's Name/Relationship (Type, Print) <b>Good Samaritan Hospital</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5601 Loch Raven Blvd Baltimore, MD 21239</b>																		
20a. Method of Disposition <b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) in state</b>				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>in state</b>		20c. Location - City or Town, State																
21. Signature of Funeral Service Licensee <b>Ronald S. Wade, Director</b>				22. Name and Address of Facility <b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>																		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																						
<table border="0"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <b>Sepsis</b></td> <td>Due to (or as a consequence of):</td> <td rowspan="4">Approximate Interval Between Onset and Death <b>Three days</b></td> </tr> <tr> <td>b. <b>Pneumonia</b></td> <td>Due to (or as a consequence of):</td> <td><b>Four days</b></td> </tr> <tr> <td>c. <b>Diabetes</b></td> <td>Due to (or as a consequence of):</td> <td><b>twenty year</b></td> </tr> <tr> <td>d. <b>Chronic pancreatitis</b></td> <td>Due to (or as a consequence of):</td> <td><b>Ten year</b></td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)	a. <b>Sepsis</b>	Due to (or as a consequence of):	Approximate Interval Between Onset and Death <b>Three days</b>	b. <b>Pneumonia</b>	Due to (or as a consequence of):	<b>Four days</b>	c. <b>Diabetes</b>	Due to (or as a consequence of):	<b>twenty year</b>	d. <b>Chronic pancreatitis</b>	Due to (or as a consequence of):	<b>Ten year</b>
Immediate Cause (Final disease or condition resulting in death)	a. <b>Sepsis</b>	Due to (or as a consequence of):	Approximate Interval Between Onset and Death <b>Three days</b>																			
	b. <b>Pneumonia</b>	Due to (or as a consequence of):		<b>Four days</b>																		
	c. <b>Diabetes</b>	Due to (or as a consequence of):		<b>twenty year</b>																		
	d. <b>Chronic pancreatitis</b>	Due to (or as a consequence of):		<b>Ten year</b>																		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Coronary artery disease</b>																						
23b. Did tobacco use contribute to the cause of death? <b>1 Yes 2 No 3 Probably 4 Unknown</b>																						
24a. Was an autopsy performed? <b>1 Yes 2 No</b>																						
24b. Were autopsy findings available prior to completion of cause of death? <b>1 Yes 2 No</b>																						
25. Was case referred to medical examiner? <b>1 Yes 2 No</b>																						
26. Place of Death (Check only one) Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>																						
27. Manner of Death <b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined</b>		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1 Yes 2 No</b>		28d. Describe how injury occurred														
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)																		
29e. Certifier (Check only one) <b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>																						
29b. Signature and title of certifier <b>Qinglin Gao, MD</b>				29c. License number <b>P14417</b>		29d. Date signed (Month, Day, Year) <b>August 17, 2000</b>																
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>The good Samaritan Hospital 5601 Loch Raven Blvd Baltimore, MD 21239</b>																						
31. Date filed (Month, Day, Year) <b>AUG 31 2000</b>		32. Registrar's Signature <b>Benjamin S. Sparks</b>																				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27536

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>GEORGE FRANKLIN GRIMM</b>				2. Date of Death Month <b>AUGUST</b> Day <b>28</b> , Year <b>2000</b>				3. Time of Death <b>7:40 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>ST. JOSEPH MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>TOWSON</b>				4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>215-10-1847</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>82</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>3/2/18</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>	
	10a. State <b>MD</b>				10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>RIDGELEIGH</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number <b>8530 OAK ROAD</b>				10f. Zip Code <b>21234</b>		10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>			
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11TH GRADE</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>TILE SETTER</b>		16b. Kind of Business/Industry <b>SELF EMPLOYED</b>			
	17. Father's Name (First, Middle, Last) <b>GEORGE DANIEL GRIMM</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>HELEN MARIE MEYERS</b>					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>MARGARET GRIMM WIFE</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8530 OAK ROAD BALTIMORE, MD 21234</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>PARKWOOD CEMETERY</b>		Date <b>8/31/00</b>		20c. Location - City or Town, State <b>BALTIMORE, MD</b>			
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286</b>					
	23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. METASTATIC COLON CANCER</b> Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>				Approximate Interval Between Onset and Death <b>2 YEARS</b>					
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29c. License number <b>D44604</b>		29d. Date signed (Month, Day, Year) <b>8/28/00</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MICHAEL SUTER, M.D. 8100 HARBOR ROAD BALTIMORE, MD 21234</b>									
To Be Completed by Physician/Medical Examiner	31. Date filed (Month, Day, Year) <b>AUG 31 2000</b>				32. Registrar's Signature 					

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27537

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Joseph Aaron Gray</u>		2. Date of Death Month <u>August</u> Day <u>27</u> Year <u>2000</u>		3. Time of Death <u>10:15 AM</u>
	4a. Facility Name (If not institution, give street and number) <u>The Johns Hopkins Hospital</u>		4b. City, Town, or Location of Death <u>Baltimore City</u>		4c. County of Death
Funeral Director	5. Social Security Number <u>218-03-1598</u>	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In Yrs. last birthday) <u>80</u> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth <u>4/17/1920</u>		9. Birthplace (State or Foreign Country) <u>Maryland</u>		
Usual Residence of Decedent					
10a. State <u>MD</u>		10b. County <u>N/A</u>		10c. City, Town or Location <u>Baltimore</u>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
10a. Street and Number <u>3503 Foster Avenue</u>			10f. Zip Code <u>21224</u>		10g. Citizen of What Country? <u>U.S.A.</u>
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <u>White</u>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Steelworker</u>		16b. Kind of Business/Industry <u>Bethlehem Steel</u>	
17. Father's Name (First, Middle, Last) <u>John W. Gray</u>			18. Mother's Name (First, Middle, Maiden Surname) <u>Margaret Knott</u>		
19a. Informant's Name/Relationship (Type, Print) <u>Judith Hudson/Daughter</u>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>932 Wampler Road Middle River, Maryland 21220</u>		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Parkwood Cemetery</u>		20c. Location - City or Town, State <u>8/30/00 Baltimore, Maryland</u>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <u>John C. Miller Inc.</u> <u>6415 Belair Road Baltimore, Maryland 21206</u>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		a. <u>Acute Inferior-Posterior Myocardial Infarction</u>			Approximate Interval Between Onset and Death <u>3 days</u>
Due to (or as a consequence of):		b. <u>Coronary Artery Disease</u>			<u>6 years</u>
Due to (or as a consequence of):		c. <u>Tobacco Use</u>			<u>50 years</u>
Due to (or as a consequence of):		d.			
Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
<u>Hypertension</u>					
<u>Hypercholesterolemia</u>					
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number <u>RES-000</u>		29d. Date signed (Month, Day, Year) <u>8/27/2000</u>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>David Shih, MD The Johns Hopkins Hospital Baltimore, MD 21205</u>					
31. Date filed (Month, Day, Year) <u>AUG 31 2000</u>		32. Registrar's Signature 			

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene

00 27538

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JESSE JAMON HODGES				2. Date of Death Month Day Year August 30 2000				3. Time of Death 3:15 p.m.	
	4a. Facility Name (If not institution, give street and number) Baptist Home of Maryland				4b. City, Town, or Location of Death Owings Mills				4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 216-05-7219		6. Sex XX M 20 F		7. Age (In yrs. last birthday) 86 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 20, 1914		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent				10a. State Maryland		10b. County Harford		10c. City, Town or Location Bel Air	
To Be Completed by Funeral Director	10d. Inside City Limits 10 Yes 20 No				10e. Street and Number 200 Timber Trail Unit F				10f. Zip Code 21014	
	10g. Citizen of What Country? U.S.A.				11. Marital Status 10 Never Married 20 Married 30 Widowed 40 Divorced				12. Was Decedent Ever in U.S. Armed Forces? 10 Yes 20 No	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 10 Yes 20 No Specify:				14. Race - American Indian, Black, White, etc. Specify: White				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Steel Worker				16b. Kind of Business/Industry Steel Company				17. Father's Name (First, Middle, Last) Jesse Hodges	
	18. Mother's Name (First, Middle, Maiden Surname) Matilda Paul				19a. Informant's Name/Relationship (Type, Print) Gladys Litz (Daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 200 Timber Trail Unit F Bel Air, Md. 21014	
	20a. Method of Disposition 10 Burial 20 Cremation 30 Removal from State 40 Donation 50 Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens of Faith				20c. Location - City or Town, State Overlea, Maryland	
	21. Signature of Funeral Service Licensee Robert M. Ybrat				22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc. 6500 York Rd. Baltimore, Maryland 21212				23a. Part I. Enter the disease, or complications that caused death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. pneumonia Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	
	23b. Did tobacco use contribute to the cause of death? 10 Yes 20 No 30 Probably 40 Unknown				24a. Was an autopsy performed? 10 Yes 20 No				24b. Were autopsy findings available prior to completion of cause of death? 10 Yes 20 No	
	25. Was case referred to medical examiner? 10 Yes 20 No				26. Place of Death (Check only one) Hospital: 10 Inpatient 20 ER/Outpatient 30 DOA Other: 40 Nursing Home 50 Residence 60 Other (Specify)				27. Manner of Death 10 Natural 20 Accident 30 Suicide 40 Homicide 50 Pending investigation 60 Could not be determined	
	28a. Date of Injury (Month, Day Year)				28b. Time of Injury M				28c. Injury at Work? 10 Yes 20 No	
28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		
29b. Signature and title of certifier [Signature]				29c. License number D41104				29d. Date signed (Month, Day, Year) 8.31.00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ted Hawk MD 7825 York Rd Towson MD 21204.				31. Date filed (Month, Day, Year) AUG 31 2000				32. Registrar's Signature [Signature]		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified in case.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

to the end of the road

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27539

## Certificate of Death

Reg. No.

Amended item#20 per FD G786 8-31-00 WJJ

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Warrell Harmon, Jr</i>				2. Date of Death Month Day Year AUGUST 29, 2000				3. Time of Death 01:00 AM				
	4a. Facility Name (If not institution, give street and number) SHOCK TRAUMA UNIT				4b. City, Town, or Location of Death BALTIMORE				4c. County of Death N/A				
Funeral Director	5. Social Security Number <i>215 86 3392</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <i>25</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>DEC 10, 1974</i>		9. Birthplace (State or Foreign Country) <i>Maryland</i>				
	10a. State <i>Maryland</i>		10b. County <i>MD</i>		10c. City, Town or Location <i>BALTIMORE</i>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						
10e. Street and Number <i>760 W. Hamburg Street</i>		10f. Zip Code <i>21230</i>		10g. Citizen of What Country? <i>USA</i>		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			
14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12th grade</i> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Laborer</i>		16b. Kind of Business/Industry <i>Private Industry</i>		17. Father's Name (First, Middle, Last) <i>Warrell Harmon, Sr</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Diane Harris</i>			
19a. Informant's Name/Relationship (Type, Print) <i>Diane Harris / Mother</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>760 W. Hamburg Street Baltimore, MD 21230</i>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Voshell Memorial Garden</i>		20c. Location - City or Town, State <i>Baltimore, Maryland</i>		21. Signature of Funeral Service Licensee <i>Benny Harris</i>			
22. Name and Address of Facility <i>CHATHAM-HARRIS Funeral Home 5340 Reisterstown Road Baltimore, Maryland 21204</i>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <i>GUNSHOT WOUND OF CHEST</i> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <i>8/29/00</i>		28b. Time of Injury <i>0035</i> M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <i>SUBJECT WAS SHOT</i>	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>J. A. [Signature], M.D.</i>		29c. License number OCME		29d. Date signed (Month, Day, Year) AUGUST 29, 2000		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <i>STREET</i>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <i>700 BLOCK WEST HAMBURG ST, BALTIMORE MD</i>			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>MARY G. RIPPLE, M.D.</i>		31. Date filed (Month, Day, Year) AUG 31 2000		32. Registrar's Signature <i>[Signature]</i>		33. Date of Death AUGUST 29, 2000		34. Registrar's Signature <i>[Signature]</i>		35. Date of Death AUGUST 29, 2000			

Baltimore, Maryland 21215-0020

Physician  
/Medical  
ExaminerDivision of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27540

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Elizabeth Hanna		2. Date of Death Month Day Year August 28 00		3. Time of Death 0115AM
	4a. Facility Name (If not institution, give street and number) Levindale Hebrew Geriatric Center		4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A
Funeral Director	5. Social Security Number 250-20-5987	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) 03 15 1918		9. Birthplace (State or Foreign Country) SC		
Usual Residence of Decedent					
10a. State Md		10b. County N/A		10c. City, Town or Location Baltimore	
10e. Street and Number 19 Bishop Gate Court		10f. Zip Code 21244		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bus Matron		16b. Kind of Business/Industry Transportation	
17. Father's Name (First, Middle, Last) Edward Wilson			18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Johnson		
19a. Informant's Name/Relationship (Type, Print) Jonathan Fields/Grandson			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1259 Loring Ave Apt 8C, Brooklyn, NY 11208		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Long Island National Cem 09 05		20c. Location - City or Town, State Farmingdale, NY	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Sterling-Ashton-Schwab Funeral Home, Inc 736 Edmondson Avenue, Balto, Md. 21228			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		a. <u>Pancreatic Cancer</u> Due to (or as a consequence of):			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. Due to (or as a consequence of):			
		c. Due to (or as a consequence of):			
		d. Due to (or as a consequence of):			
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			
28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
29b. Signature and title of certifier 		29c. License number 037573		29d. Date signed (Month, Day, Year) August 28, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jef Tihell MD 7220 Park Heights Ave Baltimore MD 21206					
31. Date filed (Month, Day, Year) AUG 31 2000		32. Registrar's Signature 			





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State of Maryland / Department of Health and Mental Hygiene

00 27541

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Brindell Horelick</b>				2. Date of Death Month Day Year <b>August 11, 2000</b>				3. Time of Death <b>8:08pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>59 Glenwood Avenue</b>				4b. City, Town, or Location of Death <b>Baltimore</b>				4c. County of Death <b>n/a</b>	
Funeral Director	5. Social Security Number <b>151-24-0069</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>67</b> Yrs.		If Under 1 Year Months Days		8. Date of Birth (Month, Day, Year) <b>Sept. 5, 1932</b>	
	9. Birthplace (State or Foreign Country) <b>NY</b>									
Usual Residence of Decedent										
10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10a. Street and Number <b>59 Glenwood Avenue</b>				10f. Zip Code <b>21228</b>				10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>54-56</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>unk</b> College (1-4 or 5+) <b>unk</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Math Professor</b>				16b. Kind of Business/Industry <b>College</b>		
17. Father's Name (First, Middle, Last) <b>Harry Horelick</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Miriam Sanderson</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Marjorie Berman/friend</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5619 Thicket Lane, Columbia, MD 21044</b>					
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)					20b. Place of Disposition (Name of cemetery, crematory or other place)			Date		20c. Location - City or Town, State
21. Signature of Funeral Service Licensee <b>Ronald S. Wade, Director</b> per DVR					22. Name and Address of Facility <b>State Anatomy Board, 655 W. Baltimore St. Baltimore, MD 21201</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
Immediate Cause (Final disease or condition resulting in death)										
a. <b>CORONARY ARTERY DISEASE</b> 4 MONTHS										
Due to (or as a consequence of):										
b. <b>HYPERTENSION</b> 10 YRS										
Due to (or as a consequence of):										
c. <b>NON INSULIN DEPENDANT DIABETES</b> 10 YRS										
Due to (or as a consequence of):										
d.										
23b. Dtd tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		5. Pending investigation		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <b>[Signature]</b>				29c. License number <b>D19317</b>				29d. Date signed (Month, Day, Year) <b>8/14/00</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>BORIS KERZNER 1838 GREENWICH RD BALTIMORE, MD 21208</b>										
31. Date filed (Month, Day, Year) <b>AUG 31 2000</b>		32. Registrar's Signature <b>[Signature]</b>								

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene 00 27542

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Ruby HARRIS</b>				2. Date of Death Month Day Year <b>AUGUST 26, 2000</b>		3. Time of Death <b>8:27am</b>	
	4a. Facility Name (If not institution, give street and number) <b>2229 BRADDISH AVE.</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>423-44-6236</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>66</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>3-2-1934</b>	
	9. Birthplace (State or Foreign Country) <b>ALABAMA</b>		10a. State <b>MD.</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>2229 BRADDISH AVE.</b>		10f. Zip Code <b>21216</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>-12-</b> College (1-4or 5+) <b>-2-</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>NURSE</b>		16b. Kind of Business/Industry <b>HEALTHCARE</b>		17. Father's Name (First, Middle, Last) <b>ERNEST KENDRICK</b>		
18. Mother's Name (First, Middle, Maiden Surname) <b>ELLEN PENN</b>		19a. Informant's Name/Relationship (Type, Print) <b>TONA HARRIS (DAUGHTER)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2018 E. CHELTEN AVE. PHILADELPHIA, PA. 19138</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		
20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GARRISON FOREST VETERANS 9-1-2000 OWINGS MILLS, MARYLAND</b>		20c. Location - City or Town, State		21. Signature of Funeral Service Licensee <i>Janatha D. Hizer</i>		22. Name and Address of Facility <b>PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. metastatic breast cancer</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):		Approximate Interval Between Onset and Death <b>4 months</b>		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		
29b. Signature and title of certifier <i>Stanley Walker</i>		29c. License number <b>044944</b>		29d. Date signed (Month, Day, Year) <b>AUGUST 28, 2000</b>		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Stanley Walker 3237 North Calvert Street Baltimore, MD</b>		
31. Date filed (Month, Day, Year) <b>AUG 31 2000</b>		32. Registrar's Signature <i>Benjamin S. Sparks</i>		State Registrar		AH		

ORIGINAL

Transit 1008

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1008 1008 1008 1008

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State of Maryland / Department of Health and Mental Hygiene 00 27543

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) SHIRLEY E. HICKS				2. Date of Death Month Day Year August 26, 2000		3. Time of Death 11:53 AM	
	4a. Facility Name (If not institution, give street and number) Maryland General Hospital				4b. City, Town, or Location of Death Baltimore City		4c. County of Death N/A	
Funeral Director	5. Social Security Number 216-84-6563		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 37 Yrs.		8. Date of Birth (Month, Day, Year) 1-30-1963	
	9. Birthplace (State or Foreign Country) MD.		10a. State MD.		10b. County N/A		10c. City, Town or Location BALTIMORE	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				10e. Street and Number 721 NEWINGTON AVE.		10f. Zip Code 21217	
	10g. Citizen of What Country? USA				11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yea or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: BLACK		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) -11- College (14 or 5+) -0-	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LABORER				16b. Kind of Business/Industry INDUSTRIAL			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) WILLIE BARNETT				18. Mother's Name (First, Middle, Maiden Surname) JOYCE HICKS			
	19a. Informant's Name/Relationship (Type, Print) EVERETTE COX (BROTHER)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1320 ROCKWELL RD. JUNCTION CITY, KS. 66441			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) MT. ZION CEMETERY			
	20c. Location - City or Town, State 8-31-2000 BALTIMORE, MARYLAND				21. Signature of Funeral Service Licensee Jonathan D. Horner			
To Be Completed by Physician/Medical Examiner	22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Mass Lesion in Brain Due to (or as a consequence of): Acquired immunodeficiency Syndrome Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			
To Be Completed by Physician/Medical Examiner	28a. Date of Injury (Month, Day Year)				28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
To Be Completed by Physician/Medical Examiner	28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
	29b. Signature and title of certifier P. Prabhakar				29c. License number 89355		29d. Date signed (Month, Day, Year) August 26, 2000	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Priya Prabhakar, MD c/o Maryland General Hospital				31. Date filed (Month, Day, Year) AUG 31 2000			
	32. Registrar's Signature Benita B. Sparks				33. Date signed (Month, Day, Year)			

SHIRLEY HICKS  
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,  
Baltimore, Maryland 21260

DMH 16 Rev 6/95

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Amended to 26 per PHYG786 8/31/2000 EW

00 27544

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DOLores JONES

2. Date of Death

August 25 2000

3. Time of Death

6:18am

4a. Facility Name (If not institution, give street and number)

Long Green, Genes's

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

USA

Funeral  
Director

5. Social Security Number

213-30-0863

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

63

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
08-29-36

9. Birthplace (State or Foreign Country)

NC

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

1713 N. Broadway

10f. Zip Code

21213

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

8th Grade

NA

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Housekeeping

16b. Kind of Business/Industry

Baltimore City

17. Father's Name (First, Middle, Last)

Leroy Miles

18. Mother's Name (First, Middle, Maiden Surname)

Corine Patmon

19a. Informant's Name/Relationship (Type, Print)

Corine Guin

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1713 N. Broadway Baltimore, Maryland

21213

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Arbutus Mem. Pk. Cem. 08-29-2000 Arbutus, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

A Ladys Wane

22. Name and Address of Facility

Baltimore, Maryland 21202  
WM.C. March FH 1101 E. North Avenue23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Carcinoma of Colon  
Due to (or as a consequence of):Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Restrictive Lung Disease

Sick Sinus Syndrome

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

A Ladys Wane

29c. License number

D17118

29d. Date signed (Month, Day, Year)

Aug 25, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paul Schwartz M.D. 115 E. McIlroy Ave 21212

31. Date filed (Month, Day, Year)

AUG 31 2000

32. Registrar's Signature

Beverly G. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
2025.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



00-222

B.K.S

00-4657-510

ANTONIO JONES

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27545

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Antonio Jones</b>				2. Date of Death Month Day Year <b>AUG. 17, 2000</b>		3. Time of Death <b>10:25 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>3000 LIBERTY HEIGHTS AVENUE- IN WOODS</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>NA</b>		
Funeral Director	5. Social Security Number <b>218-90-9136</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>26</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>10-25-73</b>		
	10a. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 9th Grade</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Laborer</b>				16b. Kind of Business/Industry <b>Job Corp.</b>	
17. Father's Name (First, Middle, Last) <b>Albert Braxton</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Barbara Jones</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Barbara Jones</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1602 E. 28th Street Baltimore, Maryland 21218</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>King Mem. Pk. Cemetery 08-31-00 Randallstown,</b>				20c. Location - City or Town, State <b>MD.</b>	
21. Signature of Funeral Service Licensee <b>Bladys Warner</b>				22. Name and Address of Facility <b>Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>Gunshot Wounds of Head</b> Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				Approximate Interval Between Onset and Death	
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>AT SCENE</b>					
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accidental <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year) <b>UNK</b>		28b. Time of Injury <b>UNK</b> M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>UNK</b>				28d. Describe how injury occurred <b>Subject shot</b>				28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>UNK</b>	
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <b>Charles Beard</b>				29c. License number <b>O.C.M.E</b>	
29d. Date signed (Month, Day, Year) <b>AUG. 18, 2000</b>				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>J. LARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201</b>					
31. Date filed (Month, Day, Year) <b>AUG 31 2000</b>				32. Registrar's Signature <b>Benjamin S. Sparks</b>					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 27546

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOHN JACKSON				2. Date of Death Month Day Year AUGUST 27 2000				3. Time of Death 2342		
	4a. Facility Name (If not institution, give street and number) UNIVERSITY OF MARYLAND HOSPITAL				4b. City, Town, or Location of Death BALTIMORE				4c. County of Death NA		
Funeral Director	5. Social Security Number 212-20-4754		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 77 Yrs.		8. Date of Birth (Month, Day, Year) 03-01-23		9. Birthplace (State or Foreign Country) MD		
	10a. State MD				10b. County NA		10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 5245 Saybrook Road				10f. Zip Code 21206				10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5th Grade NA				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Supervisor of Maintenance McDonald School				16b. Kind of Business/Industry			
17. Father's Name (First, Middle, Last) Thomas Jackson				18. Mother's Name (First, Middle, Maiden Surname) Alice Jackson							
19a. Informant's Name/Relationship (Type, Print) Joan P. Moore				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5245 Saybrook Road Baltimore, Maryland 21206							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) King Mem. Pk. Cem. 09-01-2000 Randallstown,				20c. Location - City or Town, State MD			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. TYPE I AORTIC DISSECTION. Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HIV RENAL FAILURE										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier (LUTCAVAGE)				29c. License number A0417643542444		29d. Date signed (Month, Day, Year) AUGUST 28, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UNIVERSITY OF MARYLAND HOSPITAL BALTIMORE MARYLAND 21201											
31. Date filed (Month, Day, Year) AUG 31 2000				32. Registrar's Signature 							

Baltimore, Maryland 21215-0020  
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27547

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) William Wayne Knobloch		2. Date of Death Month Day Year August 25 2000		3. Time of Death 8:31 pm
	4a. Facility Name (If not institution, give street and number) The Johns Hopkins Hospital		4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A
Funeral Director	5. Social Security Number 218-28-9911	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (in yrs. last birthday) 68 Yrs.	8. Date of Birth (Month, Day, Year) March 27, 1932	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent				
10a. State Maryland		10b. County Kent	10c. City, Town or Location Galena		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
10e. Street and Number P. O. Box 48		10f. Zip Code 21635		10g. Citizen of What Country? United States	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1955-58		13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: white		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) stock broker	
16b. Kind of Business/Industry finance		17. Father's Name (First, Middle, Last) Charle Mouring Knobloch		18. Mother's Name (First, Middle, Maiden Surname) Selma Elizabeth Baylor	
19a. Informant's Name/Relationship (Type, Print) Marcia Knobloch/wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P. O. Box 48 Galena, MD 21635			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Greenmount Crematory		20c. Location - City or Town, State 8/28/00 Baltimore, Maryland	
21. Signature of Funeral Service Licensee John D. Mitchell IV		22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Rd. Baltimore, MD 21212			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Upper Gastrointestinal Bleed Liver Failure - Cirrhosis  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  3 days 6 years		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) M		28b. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28c. Describe how injury occurred		28d. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Stephen L. Moff MD		29c. License number RES-000	
29d. Date signed (Month, Day, Year) August 25, 2000		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen L. Moff 600 North Wolfe Street Baltimore, Maryland 21287			
31. Date filed (Month, Day, Year) AUG 31 2000		32. Registrar's Signature B Sparks			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **00 27548**  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Evelyn Kimmitt

2. Date of Death

Month Day Year  
August 25 2000

3. Time of Death

1:57 PM

4a. Facility Name (If not institution, give street and number)

The Villa

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

220-54-8340

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

88

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

06/02/1912

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

6806 Bellona Avenue

10f. Zip Code

21202

10g. Citizen of What Country?

United States

11. Marital Status

☒ Never Married ☐ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: White15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Religious Sister

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

John J. Kimmitt

18. Mother's Name (First, Middle, Maiden Summa)

Elsie Meushaw

19a. Informant's Name/Relationship (Type, Print)

Sr. Marcia McKinley

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 11448 Baltimore, Maryland 21202

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Woodlawn Cemetery

Date

8/28

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Robert J. Schabert

22. Name and Address of Facility

Sterling-Ashton-Schwab Funeral Home, Inc.  
736 Edmondson Avenue Catonsville, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. metastatic breast cancer  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 Yr<sup>+</sup>

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael O. Kroun, MD

29c. License number

031865

29d. Date signed (Month, Day, Year)

August 25, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rm 206 821 North Euter street, Baltimore, md 21201

31. Date filed (Month, Day, Year)

AUG 31 2000

32. Registrar's Signature

Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 206A.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

ORIGINAL

1900


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27549

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ISIAH HOWARD KENLY				2. Date of Death Month Day Year August 25 2000		3. Time of Death 0542	
	4a. Facility Name (If not institution, give street and number) HARFORD MEMORIAL HOSPITAL				4b. City, Town, or Location of Death HAVRE DE GRACE		4c. County of Death HARFORD	
Funeral Director	5. Social Security Number 218-03-8521	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) NOV 28 1919		9. Birthplace (State or Foreign Country) MARYLAND
	Usual Residence of Decedent							
10a. State MARYLAND		10b. County HARFORD		10c. City, Town or Location ABERDEEN		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 20 SPESUTIA ROAD				10f. Zip Code 21001		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7th grade				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) FORK LIFT SUPERVISOR		16b. Kind of Business/Industry SALVAGE YARD		
17. Father's Name (First, Middle, Last) GEORGE W. KENLY				18. Mother's Name (First, Middle, Maiden Surname) HATTIE J HOLLINGSWORTH				
19a. Informant's Name/Relationship (Type, Print) Wanda Burrell/ Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 624 Yorkshire Dr., Edgewood, Maryland 21040				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MT CALVARY/BUSH CHAPL		20c. Location - City or Town, State 8-30-00 ABERDEEN, MARYLAND				
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 321 S. PHILADELPHIA BLVD, ABERDEEN, MARYLAND				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) Sepsis, Septic Shock. Due to (or as a consequence of): UTI. Neutropenia. Due to (or as a consequence of): Immunocompromise HIV. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HIV+ Metastatic Liver disease Adenocarcinoma								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number D0053622		29d. Date signed (Month, Day, Year) 8-25-00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 319 South Union Ave Havre de Grace M.D.								
31. Date filed (Month, Day, Year) AUG 31 2000		32. Registrar's Signature 						

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27550

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Francis Dominic Murnaghan, Jr.				2. Date of Death Month Day Year August 31 2000		3. Time of Death 12:53 PM														
	4a. Facility Name (If not institution, give street and number) Gilchrist Center				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore														
Funeral Director	5. Social Security Number 215-16-7774		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) June 20, 1920														
	10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No														
To Be Completed by Funeral Director	10e. Street and Number 6 W. Mt. Vernon Place				10f. Zip Code 21201		10g. Citizen of What Country? United States														
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1942-46		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white														
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) associate judge		16b. Kind of Business/Industry federal government														
	17. Father's Name (First, Middle, Last) Francis Dominic Murnaghan				18. Mother's Name (First, Middle, Maiden Surname) Ada Kimball																
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Diana Edwards Murnaghan/wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 W. Mt. Vernon Place Baltimore, MD 21201																
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Greenmount Crematory		Date 9/1/00		20c. Location - City or Town, State Baltimore, Maryland														
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee John D. Mitchell IV				22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Rd. Baltimore, MD 21212																
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <table border="1"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>a. Acute renal failure</td> <td>Approximate Interval Between Onset and Death</td> <td>4 weeks</td> </tr> <tr> <td rowspan="4">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</td> <td>b. Diffuse Vascular disease</td> <td></td> <td>years</td> </tr> <tr> <td>c.</td> <td></td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. Acute renal failure	Approximate Interval Between Onset and Death	4 weeks	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Diffuse Vascular disease		years	c.			d.	
Immediate Cause (Final disease or condition resulting in death)	a. Acute renal failure	Approximate Interval Between Onset and Death	4 weeks																		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Diffuse Vascular disease		years																		
	c.																				
	d.																				
	To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown													
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No															
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Hospice														
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No														
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred						28e. Location (Street and Number or Rural Route Number, City or Town, State)														
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						29b. Signature and title of certifier W. A. Riley, MD														
To Be Completed by Physician/Medical Examiner	29c. License number D25205						29d. Date signed (Month, Day, Year) August 31, 2000														
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. A. Riley, MD 6701 N. Charles St. Balto. md 2120x																				
State Registrar	31. Date filed (Month, Day, Year) AUG 31 2000				32. Registrar's Signature P. Sparks																

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27551

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

PHILBERT EBENEZER MELVILLE

2. Date of Death

Month

Day

Year

August 28 2000 6:40 PM

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Stella Maris at Mercy Hospital

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

216 62 8199

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

6. Date of Birth

(Month, Day, Year)

FEB 11, 1934

9. Birthplace (State or Foreign Country)

TARAGO, W.I

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

5312 Gist Avenue

10f. Zip Code

21215

10g. Citizen of What Country?

WEST INDIES

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

10th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

WELDER

16b. Kind of Business/Industry

Bethlehem Steel

17. Father's Name (First, Middle, Last)

JAMES MELVILLE

18. Mother's Name (First, Middle, Maiden Surname)

Cecelia Boveil

19a. Informant's Name/Relationship (Type, Print)

STEVE MELVILLE Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

745 Palmer Court Lake Mary, Florida 32746

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

KING Memorial Park

Date

9/1/2000

20c. Location - City or Town, State

Woodlawn, Maryland

21. Signature of Funeral Service Licensee

Dorothy Harris

22. Name and Address of Facility

CHATHAM - Harris Funeral Home

5340 KESTERMAN ROAD

BALTIMORE, Maryland 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MESOTHELIOMA OF LUNG

Due to (or as a consequence of):

Approximate interval Between Onset and Death

8 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

{

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

STELLA MARIS AT MERCY

HOSPICE

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dorothy Harris MD

29c. License number

D40854

29d. Date signed (Month, Day, Year)

August 29, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID RISEBERG 301 ST PAUL PI

BALTIMORE MD 21202

31. Date filed (Month, Day, Year)

AUG 31 2000

32. Registrar's Signature

Dorothy Harris

State  
Registrar

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27552

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Charles W. McComas				2. Date of Death Month Day Year 08 27 2000		3. Time of Death 2:55 a.m.	
	4a. Facility Name (If not institution, give street and number) 8109 Candle Lane				4b. City, Town, or Location of Death Rosedale		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 216-24-0297	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 71 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 09 12 1928		9. Birthplace (State or Foreign Country) Md
	Usual Residence of Decedent							
10a. State Md		10b. County Baltimore		10c. City, Town or Location Rosedale		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 8109 Candle Lane				10f. Zip Code 21237		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver		16b. Kind of Business/Industry Freight Company		
17. Father's Name (First, Middle, Last) Harry James McComas				18. Mother's Name (First, Middle, Maiden Surname) Rose Mary Mehan				
19a. Informant's Name/Relationship (Type, Print) Lotus McComas/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8109 Candle Lane, Rosedale, Md. 21237				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) Entomb.		20b. Place of Disposition (Name of cemetery, crematory or other place) Holly Hill Maus.		20c. Location - City or Town, State 08 30 Baltimore, Md		20d. Date		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Bradley-Ashton-Matthews Funeral Home, Inc 2134 Willow Spring Road, Balto, Md. 21222				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. ASCVD b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death 20 yrs								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number D16770		29d. Date signed (Month, Day, Year) 8/30/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID GOLDSSEWER - 200 E 33rd St, Balto MD 21218								
31. Date filed (Month, Day, Year) AUG 31 2000				32. Registrar's Signature 				

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27553

AMENDED ITEM #26 PER MD G786 8/31/00 AH

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) Robbie Lue Moore				2. Date of Death Month Day Year August 3, 2000		3. Time of Death 9:40 AM	
Funeral Director		4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital				4b. City, Town, or Location of Death Takoma Park, Md.		4c. County of Death Montgomery	
5. Social Security Number 578-38-7352		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 73 Yrs.		8. Date of Birth (Month, Day, Year) 7-31-27		9. Birthplace (State or Foreign Country) South Carolina	
Usual Residence of Decedent									
10a. State Md.		10b. County Prince Georges		10c. City, Town or Location Mount Rainier				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 3001 Queens Chapel Road				10f. Zip Code 20712		10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Social Worker			16b. Kind of Business/Industry Salvation Army		
17. Father's Name (First, Middle, Last) Robert Morgan					18. Mother's Name (First, Middle, Maiden Surname) Magnolia Harris				
19a. Informant's Name/Relationship (Type, Print) Robert Edward Moore (son)					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10511 Foxlake Drive, Mitchellville, Md. 20721				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln		Date 8/10/00		20c. Location - City or Town, State Bladensburg, Md.			
21. Signature of Funeral Service Licensee  CC0348					22. Name and Address of Facility Latney's Funeral Home, Inc. 3831 Georgia Ave., NW Washington, DC 20011				
Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
Immediate Cause (Final disease or condition resulting in death) Pulmonary Edema Due to (or as a consequence of):									
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension Diabetes Renal Insufficiency									
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier 					29c. License number D24547		29d. Date signed (Month, Day, Year) 8/30/2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Martin H. Brown 7600 Carroll Ave Takoma Park, Md, 20912									
31. Date filed (Month, Day, Year) AUG 31 2000					32. Registrar's Signature 				

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 27551  
Date of Death: August 27, 2000  
Time of Death: 1140 AM

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Isabell McCallister

4a. Facility Name (If not institution, give street and number)

Fallston General Hospital

4b. City, Town, or Location of Death

Fallston

4c. County of Death

Harford

Funeral  
Director

5. Social Security Number

231-30-8476

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

MAR 8, 1916

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Belair

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

410 E. MacPhail Road

10f. Zip Code

21014

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
6

College (13-16)  
5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

James Millard Wright

18. Mother's Name (First, Middle, Maiden Surname)

Hester Garland

19a. Informant's Name/Relationship (Type, Print)

Cynthia Stephenson/Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4050 N. 41st Street McLean, VA 22101

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory Inc.

Date

8-30-00

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Edward A. Gregorich

22. Name and Address of Facility

Cremation Society of MD, Inc.  
299 Frederick Road Baltimore, MD 21228

23a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Severe Metabolic anomaly.

Approximate Interval Between Onset and Death

4 days

Due to (or as a consequence of):

b. Lactic Acidosis

4 day

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Malnutrition, old age.

Hypertension, renal failure

Dehydration

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Isabell McCallister MD

29c. License number

D32009

29d. Date signed (Month, Day, Year)

8/27/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kenneth William Smith 1106 Revolution St House De Gram MD 21078

31. Date filed (Month, Day, Year)

AUG 31 2000

32. Registrar's Signature

James P. Sparks

State  
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

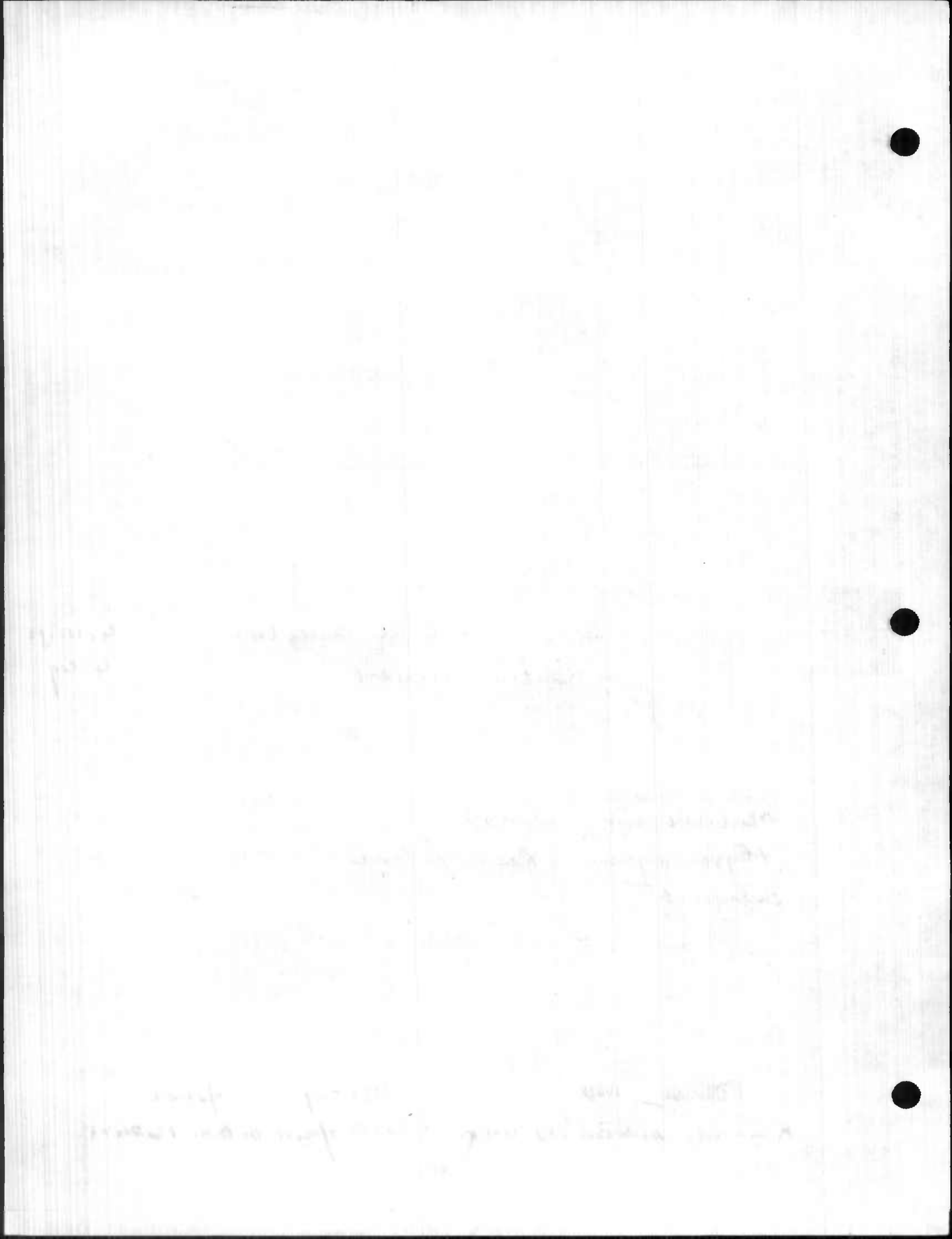
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

PER. MEO G787 9-6-00 WR.

AMEND ITEMS: #23 PART I, 27, 28A-F

Certificate of Death

Reg. No.

00 27555

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Daniel Francis Mackie</b>				2. Date of Death Month <b>August</b> Day <b>27</b> , Year <b>2000</b>				3. Time of Death <b>1:15 am</b>		
	4a. Facility Name (If not institution, give street and number) <b>Shock Trauma</b>				4b. City, Town, or Location of Death <b>Baltimore</b>				4c. County of Death <b>N/A</b>		
Funeral Director	5. Social Security Number <b>219-11-2740</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>25</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>APR 11, 1975</b>		9. Birthplace (State or Foreign Country) <b>Washington DC</b>		
	10a. State <b>Maryland</b>		10b. County <b>Howard</b>		10c. City, Town or Location <b>Mt. Airy</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
10e. Street and Number <b>700 West Watersville Road</b>		10f. Zip Code <b>21771</b>		10g. Citizen of What Country? <b>USA</b>							
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b>		College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Never Worked</b>		16b. Kind of Business/Industry <b>N/A</b>					
17. Father's Name (First, Middle, Last) <b>John Mackie</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Therese Guyot</b>							
19a. Informant's Name/Relationship (Type, Print) <b>Francis D. Mackie/Brother</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>17701 Moore Rd. Dickerson, MD 20842</b>							
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory Inc.</b>		Date <b>8-30-00</b>		20c. Location - City or Town, State <b>Baltimore, MD</b>					
21. Signature of Funeral Service Licensee <b>Thomas Gregor</b>				22. Name and Address of Facility <b>Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>CARBON MONOXIDE POISONING</b>		a. Due to (or as a consequence of):		b. Due to (or as a consequence of):		c. Due to (or as a consequence of):		d. Due to (or as a consequence of):		Approximate Interval Between Onset and Death	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>FOUND 8-26-00</b>		28b. Time of Injury <b>FOUND 12:55</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>INHALED EXHAUST FUMES FROM MOTOR VEHICLE</b>			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>RESIDENCE</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>700 W. WATERSVILLE RD. MT. AIRY, MARYLAND</b>							
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Dennis J. Chute</b>				29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>August 29, 2000</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dennis Chute</b> <b>111 Penn Street, Baltimore, Maryland 21201</b>											
31. Date filed (Month, Day, Year) <b>AUG 31 2000</b>		32. Registrar's Signature <b>Sparks</b>									

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27556

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Silas Preston Martin</b>				2. Date of Death Month <b>8</b> Day <b>23</b> Year <b>00</b>		3. Time of Death <b>8:30 a.m.</b>	
	4a. Facility Name (If not institution, give street and number) <b>3805 Mt. Carmel Road</b>				4b. City, Town, or Location of Death <b>Upperco</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>219-18-8950</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>75</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>May 14, 1925</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10. Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Baltimore</b> 10c. City, Town or Location <b>Upperco</b> 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		11. Manner of Death 11a. Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Carpenter</b>		16b. Kind of Business/Industry <b>Baltimore County</b>		17. Father's Name (First, Middle, Last) <b>Benton Edward Martin</b>	
	18. Mother's Name (First, Middle, Maiden Surname) <b>Nettie McComas</b>		19a. Informant's Name/Relationship (Type, Print) <b>Wesley Martin, Sr, son</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>18910 Falls Rd, Hampstead, MD 21074</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <b>Steven W. Elae</b>		22. Name and Address of Facility <b>Eline Funeral Home</b> <b>934 South Main St, Hampstead, MD 21074</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>a. Leucostasis</b> <b>b. Acute Myelocytic Leukemia</b> <b>c.</b> <b>d.</b>		Approximate Interval Between Onset and Death <b>3 month</b>	
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Philip J. Burke MD</b>		29c. License number <b>D04218</b>		29d. Date signed (Month, Day, Year) <b>8/29/2000</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>The Johns Hopkins Oncology Center, 601 N. Wolfe St., Baltimore, MD 21205</b>		31. Date filed (Month, Day, Year) <b>AUG 30 2000</b>		32. Registrar's Signature <b>Sparks</b>		33. State Registrar	

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

00 27557

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>James L. Murphy</b>				2. Date of Death Month <b>August</b> Day <b>29</b> Year <b>2000</b>				3. Time of Death <b>5:30 p.m.</b>	
	4a. Facility Name (If not institution, give street and number) <b>3802 Wean Drive Apt. 1E</b>				4b. City, Town, or Location of Death <b>Perry Hall</b>				4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>214-14-8254</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>80</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>April 1, 1920</b>		9. Birthplace (State or Foreign Country) <b>Baltimore, Md.</b>	
	10e. State <b>Md.</b>				10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Perry Hall</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number <b>3802 Wean Drive Apt. 1E</b>				10f. Zip Code <b>21236</b>		10g. Citizen of What Country? <b>United States</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WW II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Optician</b>				16b. Kind of Business/Industry <b>Optical</b>	
	17. Father's Name (First, Middle, Last) <b>Terrence J. Murphy</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Anna M. Ryan</b>					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Susan M. Murphy (Daughter)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5504 Adleigh Avenue Baltimore, Maryland 21206</b>					
	20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Dulaney Valley Memorial</b>		Date <b>9/2/00</b>		20c. Location - City or Town, State <b>Timonium Maryland</b>	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <b>Milton J. Knight Jr</b> <i>Milton J. Knight Jr</i>				22. Name and Address of Facility <b>Leonard J. Ruck, Inc.</b> <b>5305 Harford Road Baltimore, Maryland 21214</b>					
	23a. Part I. Enter the disease or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Atherosclerotic Cardiovascular Disease</b> Due to (or as a consequence of): <b>Hypertension</b> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b></b>				Approximate Interval Between Onset and Death <b></b>					
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b></b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year) <b></b>		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b></b>				28d. Describe how injury occurred <b></b>					
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29c. License number <b>028693</b>					
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier <i>Milton M. Friedlander</i>				29d. Date signed (Month, Day, Year) <b>August 30, 2000</b>					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>NEAL M. FRIEDLANDER 6565 N. Charles St, Suite 408 Baltimore, Md 21204</b>									
State Registrar	31. Date filed (Month, Day, Year) <b>AUG 31 2000</b>				32. Registrar's Signature <i>Benjamin S. Sparks</i>					

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

AMEND #1 PER MD. 8789 11-16-2000 JAB

00 27558

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Torance C. Magwood</b>				2. Date of Death Month <b>Aug</b> Day <b>29</b> Year <b>00</b>				3. Time of Death <b>0600</b>	
	4a. Facility Name (If not institution, give street and number) <b>DEATON SPECIALITY HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>				4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>217-86-0884</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>35</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Apr 20, 1965</b>		9. Birthplace (State or Foreign Country) <b>MD</b>	
	Usual Residence of Decedent									
10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>1809 Eagle Street</b>				10f. Zip Code <b>21217</b>				10g. Citizen of What Country? <b>United States</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4or 5+) <b>Laborer</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Laborer</b>				16b. Kind of Business/Industry <b>Convenience Store</b>		
17. Father's Name (First, Middle, Last) <b>Marshall A. Magwood, Sr.</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Virginia Gross</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Marshall A. Magwood,</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1809 Eagle Street, Baltimore, MD 21217</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mount Zion Cemetery</b>			Date <b>Sep 2 2000</b>		20c. Location - City or Town, State <b>Baltimore, MD</b>		
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>Smith &amp; Williams Funeral Home, P.A. 2818 East Baltimore Street Baltimore, MD</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a. <b>Hepatic Failure</b> Due to (or as a consequence of): b. <b>Disseminated Mycobacterium Avium Complex</b> Due to (or as a consequence of): c. <b>Acquired Immuno deficiency Syndrome</b> Due to (or as a consequence of): d.										days {
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Candida Esophagitis</b>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
			28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner			29b. Signature and title of certifier <b>Carla S. Alexander MD</b>							
			29c. License number <b>D27087</b>				29d. Date signed (Month, Day, Year) <b>8/29/00</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>CARLA S. ALEXANDER, MD 29 S. Greene St. Suite 300 Balt. Md 21201</b>										
31. Date filed (Month, Day, Year) <b>AUG 31 2000</b>			32. Registrar's Signature 							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

00 27559

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Esther Myers</b>				2. Date of Death Month Day Year <b>August 23, 2000</b>		3. Time of Death <b>12:05 AM</b>	
	4a. Facility Name (If not Institution, give street and number) <b>Sinai Hospital of Baltimore</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>060-20-3830</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs, last birthday) <b>83</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>9 3 1916</b>	
	9. Birthplace (State or Foreign Country) <b>S. C.</b>		10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>2520 Edgewood Circle North</b>		10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>American</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Home Maker</b>		16b. Kind of Business/Industry <b>Own Home</b>				
17. Father's Name (First, Middle, Last) <b>Blain M. Pou</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ellen Brown</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Mrs Hattie Clayburn (Sister)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>16 Taylor St. Stamford Conn. 06902</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Rockville Cem.</b>		20c. Location - City or Town, State <b>8/31/00 Lynbrook Long Island NY</b>				
21. Signature of Funeral Service Licensee <b>Joseph L. Russ</b>				22. Name and Address of Facility <b>Joseph L. Russ Funeral Home 2222 W. North Ave. Baltimore, Md. 21215</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Atherosclerotic Cardiovascular Disease years</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Cerebrovascular Accident</b> <b>Advance Rheumatoid Arthritis</b> <b>Severe Dehydration</b>								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and Title of certifier <b>Steven L. Soffe, M.D.</b>				29c. License number <b>D25379</b>		29d. Date signed (Month, Day, Year) <b>August 23, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Steven L. Soffe, M.D. Sinai Hospital 2140 W. Belvedere Baltimore, MD</b>								
31. Date filed (Month, Day, Year) <b>AUG 31 2000</b>				32. Registrar's Signature <b>[Signature]</b>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27560

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John J. Nolan, Jr.				2. Date of Death Month Day Year 08/27/2000		3. Time of Death 11:15 a.m.	
	4a. Facility Name (If not institution, give street and number) Forest Haven Nursing Home				4b. City, Town, or Location of Death Catonsville		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 213-12-4486	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. 79	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 03 24 1921		9. Birthplace (State or Foreign Country) Md
	Usual Residence of Decedent							
10a. State Md		10b. County N/A		10c. City, Town or Location Baltimore			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number 113 S. Augusta Avenue				10f. Zip Code 21229		10g. Citizen of What Country? USA		
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4+				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Accountant			16b. Kind of Business/Industry St. of Maryland	
17. Father's Name (First, Middle, Last) John J. Nolan, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Marie Bannon				
19a. Informant's Name/Relationship (Type, Print) Dr. Philip Nolan, Brother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8414 Allison Lane, Baltimore, Md. 21237				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) New Cathedral Cemetery		Date 08/31		20c. Location - City or Town, State Baltimore, Md.		
21. Signature of Funeral Service Licensee John J. Nolan				22. Name and Address of Facility Sterling-Ashton-Schwab Funeral Home, Inc 736 Edmondson Avenue, Baltimore, Md. 21228				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. PNEUMONIA Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death Few days
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Syed M.A. Riaz				29c. License number D40491		29d. Date signed (Month, Day, Year) 08/28/2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SYED M.A. RIAZ 800 NOVA HAMMONS FERRY RD LINTHUM MD 21090								
31. Date filed (Month, Day, Year) AUG 31 2000				32. Registrar's Signature B. Sparks				

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

00 27561

Amended Item#28a-f perPhyG787 9/12/2000 EW

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LEWIS NELSON</b>		2. Date of Death Month <b>Aug.</b> Day <b>26</b> Year <b>2000</b>		3. Time of Death <b>4:18 PM</b>						
	4a. Facility Name (If not institution, give street and number) <b>University of Maryland Medical System</b>		4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>						
Funeral Director	5. Social Security Number <b>212-34-2077</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>62</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.						
	8. Date of Birth (Month, Day, Year) <b>12/ 4/ 1937</b>		9. Birthplace (State or Foreign Country) <b>MD</b>								
Usual Residence of Decedent											
10a. State <b>MD</b>		10b. County <b>Carroll</b>		10c. City, Town or Location <b>Westminster</b>							
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
10e. Street and Number <b>447 Baronets Court</b>		10f. Zip Code <b>21157</b>		10g. Citizen of What Country? <b>USA</b>							
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>56-58</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:							
14. Race - American Indian, Black, White, etc. Specify: <b>white</b>											
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8 th</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Truck Driver</b>		16b. Kind of Business/Industry <b>Transportation</b>							
17. Father's Name (First, Middle, Last) <b>Lewis C. Nelson Sr.</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Carolyn Kessler</b>									
19a. Informant's Name/Relationship (Type, Print) <b>Teresa Lyn Jones (daughter)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>830 Angel Valley Court Edgewood, MD 21040</b>									
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Lakeview Memorial Cem.</b>		20c. Location - City or Town, State <b>8/30/00 Sykesville, MD</b>							
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>11824 Reisterstown Road Eline Funeral Home Reisterstown, MD 21136</b>									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
<table border="1"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last         </td> <td>a. <b>Intra Oral Shotgun Wound</b> Due to (or as a consequence of):</td> <td rowspan="4">           Approximate Interval Between Onset and Death         </td> </tr> <tr> <td>b. Due to (or as a consequence of):</td> </tr> <tr> <td>c. Due to (or as a consequence of):</td> </tr> <tr> <td>d. Due to (or as a consequence of):</td> </tr> </table>						Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. <b>Intra Oral Shotgun Wound</b> Due to (or as a consequence of):	Approximate Interval Between Onset and Death	b. Due to (or as a consequence of):	c. Due to (or as a consequence of):	d. Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. <b>Intra Oral Shotgun Wound</b> Due to (or as a consequence of):	Approximate Interval Between Onset and Death									
	b. Due to (or as a consequence of):										
	c. Due to (or as a consequence of):										
	d. Due to (or as a consequence of):										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown											
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) <b>Aug 25, 2000</b>		28b. Time of Injury <b>Found 4:27 PM</b>							
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>Self-Inflicted</b>		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Home</b>							
28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>447 Baronets Ct Westminster, MD</b>											
29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier 		29c. License number <b>9694</b>		29d. Date signed (Month, Day, Year) <b>Aug. 30, 2000</b>							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Melvin Stone, M.D. 22 South Greene St. Baltimore, Md 21201</b>											
31. Date filed (Month, Day, Year) <b>AUG 31 2000</b>		32. Registrar's Signature 									





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

amend item 16a,b per informant G787 State of Maryland / Department of Health and Mental Hygiene  
 amended item #8 per fh g786 8/31/00 ah yf 9/12/00

Certificate of Death

Reg. No.

00 27562

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>James Kenneth Pattillo</b>					2. Date of Death Month Day Year <b>08 27 2000</b>		3. Time of Death <b>4:00 a.m.</b>	
	4a. Facility Name (If not institution, give street and number) <b>5678 French Avenue</b>					4b. City, Town, or Location of Death <b>Sykesville</b>		4c. County of Death <b>Carroll</b>	
Funeral Director	5. Social Security Number <b>422-56-6651</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>56</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>04/12/1944</b>		9. Birthplace (State or Foreign Country) <b>Alabama</b>
	Usual Residence of Decedent								
10a. State <b>MD</b>		10b. County <b>Carroll</b>		10c. City, Town or Location <b>Sykesville</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>5678 French Avenue</b>				10f. Zip Code <b>21784</b>		10g. Citizen of What Country? <b>United States</b>			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>Vietnam</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>computer/software engineer</b> <del>Federal Employee</del>			16b. Kind of Business/Industry <b>Computer Science Corporation</b> <del>National Security Agency</del>		
17. Father's Name (First, Middle, Last) <b>James Louis Pattillo</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Margaret Nichols</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Barbara J. Pattillo Wife</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5678 French Avenue, Sykesville, MD 21784</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MD Veteran's Cemetery</b>		Date <b>8/31</b>		20c. Location - City or Town, State <b>Crownsville, MD</b>		
21. Signature of Funeral Service Licensee					22. Name and Address of Facility <b>Sterling-Ashton-Schwab Funeral Home, Inc.</b> <b>736 Edmondson Avenue Catonsville, MD 21228</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Liver Failure</b> Due to (or as a consequence of): b. <b>Hepatitis C</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Cachexia</b>							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier <b>Lawrence Siverberg</b>					29c. License number <b>HD 22076</b>		29d. Date signed (Month, Day, Year) <b>08/28/2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Lawrence Siverberg P.O. Box 257 West Friendship, Maryland 21794</b>									
31. Date filed (Month, Day, Year) <b>AUG 31 2000</b>			32. Registrar's Signature <b>Sparks</b>						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

ALH 10



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #23 PART I, 27, 28A-F PER MEO G787 9-111-00 WR.

## Certificate of Death

Reg. No.

00 27563

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Barbara Pratt				2. Date of Death Month Day Year August 28, 2000		3. Time of Death 6:00 A.M.	
	4a. Facility Name (If not institution, give street and number) Johns Hopkins Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 214-84-7471	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 39 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Mar 9, 1961		9. Birthplace (State or Foreign Country) MD
	Usual Residence of Decedent							
10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number 723 North Carey Street				10f. Zip Code 21217		10g. Citizen of What Country? United States		
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cashier			16b. Kind of Business/Industry Restaurant	
17. Father's Name (First, Middle, Last) Robert Williams				18. Mother's Name (First, Middle, Maiden Surname) Barbara Ann Pratt				
19a. Informant's Name/Relationship (Type, Print) Mr. Robert Williams-Father				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 723 North Carey Street, Baltimore, MD 21217				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Voshell Memorial Park		Date Sep 5 2000		20c. Location - City or Town, State Baltimore, MD
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Smith & Williams Funeral Home, P.A. 2818 East Baltimore Street Baltimore, MD				
23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ACUTE SUBARACHNOID HEMORRHAGE COMPLICATING ACUTE COCAINE AND NARCOTIC INTOXICATION								Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):								
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of):								
Due to (or as a consequence of):								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
								24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input checked="" type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year) Found: 8-27-00		28b. Time of Injury Found: 2:15		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
				28d. Describe how injury occurred UNKNOWN		28e. Location (Street and Number or Rural Route Number, City or Town, State) 723 N. CAREY ST. BALTIMORE, MARYLAND		
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) August 29, 2000
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis Chute M.D. 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) AUG 31 2000				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

perml. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27564

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOHN ANDREW RATIGAN JR.				2. Date of Death Month Day Year August 29, 2000		3. Time of Death 2:28pm	
	4a. Facility Name (If not institution, give street and number) Greater Baltimore Medical Center				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 219-18-2525		6. Sex XX M 2 F		7. Age (In yrs. last birthday) 76 Yrs.		8. Date of Birth (Month, Day, Year) July 14, 1924	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Towson	
To Be Completed by Funeral Director	10d. Inside City Limits 1 Yes 2 No XX		10e. Street and Number 8415 Bellona Lane		10f. Zip Code 21204		10g. Citizen of What Country? USA	
	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced XX		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No XX		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Salesman		16b. Kind of Business/Industry Food			
	17. Father's Name (First, Middle, Last) John Andrew Ratigan Sr				18. Mother's Name (First, Middle, Maiden Surname) Lily Buck			
	19a. Informant's Name/Relationship (Type, Print) Barbara J Ratigan DTR				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1207 Robin Hood Circle Towson, Maryland 21204			
	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) XX		20b. Place of Disposition (Name of cemetery, crematory or other place) Greenmount Cemetery		20c. Date 8/31/00		20d. Location - City or Town, State Baltimore, Maryland	
	21. Signature of Funeral Service Licensee Dennis Stephan Kenakis		22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. aspiration pneumonia Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown XX							
	24a. Was an autopsy performed? 1 Yes 2 No XX							
24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.	25. Was case referred to medical examiner? 1 Yes 2 No XX				26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)			
	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined XX		28a. Date of Injury (Month, Day, Year) M		28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier Timothy Jiang		29c. License number D54967		29d. Date signed (Month, Day, Year) 8/30/00			
10	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Timothy Jiang 6701 N. Ches St Towson 21204							
	31. Date filed (Month, Day, Year) AUG 31 2000				32. Registrar's Signature Dennis S. Sparks			

ORIGINAL

2

1



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27565

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) <b>PEARL ELIZABETH ROBINSON</b>		2. Date of Death Month <b>August</b> Day <b>28</b> Year <b>2000</b>		3. Time of Death <b>3:30</b>
4a. Facility Name (If not institution, give street and number) <b>SINAI HOSPITAL OF BALTIMORE</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>
5. Social Security Number <b>212 34 8569</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>88</b> Yrs.	If Under 1 Year Months Days	8. Date of Birth (Month, Day, Year) <b>Mar. 15, 1912</b>
9. Birthplace (State or Foreign Country) <b>Maryland</b>				
10a. State <b>Maryland</b>	10b. County <b>N/A</b>	10c. City, Town or Location <b>BALTIMORE</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number <b>5211 ROSWORTH AVE</b>		10f. Zip Code <b>21207</b>		10g. Citizen of What Country? <b>USA</b>
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7th grade</b> College (1-4 or 5+) <b>Domestic</b>		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Domestic</b>		16b. Kind of Business/Industry <b>Private family</b>		
17. Father's Name (First, Middle, Last) <b>THOMAS GREEN</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Pinkney Brown</b>		
19a. Informant's Name/Relationship (Type, Print) <b>RANDOLPH SHEPPARD / son</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>313 S. East Street Baltimore, Md 21224</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>WOODLAWN Cemetery</b>		20c. Location - City or Town, State <b>WOODLAWN, Maryland</b>
21. Signature of Funeral Service Licensee <b>Gray Harris</b>		22. Name and Address of Facility <b>CHATHAM - Harris Funeral Home 5240 REISTERSTOWN ROAD BALTIMORE, Md 21215</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Pneumonia</b> Due to (or as a consequence of): b. <b>CONGESTIVE HEART FAILURE</b> Due to (or as a consequence of): c. <b>LUNG MASS</b> Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last				
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HYPOTHYROIDISM, CORONARY ARTERY DISEASE, ATRIAL FIBRILLATION, HYPERTENSION, DEEP VENOUS THROMBOSIS, GASTROINTESTINAL BLEED.</b>				
23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. Signature and title of certifier <b>Justin E. Eichen MD</b>		29c. License number <b>019678</b>		29d. Date signed (Month, Day, Year) <b>AUGUST 28, 2000</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>SINAI HOSPITAL OF BALTIMORE 2401 W. Belvedere Baltimore, MD 21215</b>				
31. Date filed (Month, Day, Year) <b>AUG 31 2000</b>		32. Registrar's Signature <b>[Signature]</b>		

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

PEARL ELIZABETH ROBINSON

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27566

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Eva Rittershofer</b>		2. Date of Death Month <b>August</b> Day <b>28</b> Year <b>2000</b>		3. Time of Death <b>1:51 pm</b>
	4a. Facility Name (If not institution, give street and number) <b>Union Memorial Hospital</b>		4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>
Funeral Director	5. Social Security Number <b>217-14-2557</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>79</b> Yrs.	If Under 1 Year Months <b>0</b> Days <b>0</b>	If Under 24 Hrs. Hours <b>0</b> Min. <b>0</b>
	8. Date of Birth (Month, Day, Year) <b>04/30/1921</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
Usual Residence of Decedent					
10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Catonsville</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <b>6123 Wheatland Road</b>			10f. Zip Code <b>21228</b>		10g. Citizen of What Country? <b>United States</b>
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Supervisor</b>		16b. Kind of Business/Industry <b>C&amp;P Telephone</b>	
17. Father's Name (First, Middle, Last) <b>Wilbert Rittershofer</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Mary A. Glennon</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Mary Rittershofer Sister</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6123 Wheatland Rd Catonsville, MD 21228</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Baltimore Cemetery</b>		20c. Location - City or Town, State <b>8/31 Baltimore, Maryland</b>	
21. Signature of Funeral Service Licensee <b>Robert J. Schwab</b>		22. Name and Address of Facility <b>Sterling-Ashton-Schwab Funeral Home, Inc. 736 Edmondson Avenue, Catonsville, MD 21228</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Angiodysplasia</b> Due to (or as a consequence of): <b>b. Hypotension</b> Due to (or as a consequence of): <b>c. Dehydration</b> Due to (or as a consequence of): <b>d.</b>					
Approximate Interval Between Onset and Death <b>18 months</b> <b>3 days</b> <b>7 days</b>					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) <b>8/31</b>		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and Title of certifier <b>K. Wilson MD</b>		29c. License number <b>AT 2438946 A9</b>		29d. Date signed (Month, Day, Year) <b>August 28, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Kathleen Wilson 201 E. University Pkwy Baltimore, MD 21218</b>					
31. Date filed (Month, Day, Year) <b>AUG 31 2000</b>		32. Registrar's Signature <b>[Signature]</b>			



Reg. No.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27568

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) PAULINE G. SUTHERLAND				2. Date of Death Month Day Year August 29, 2000				3. Time of Death 12:19 P.M.	
	4a. Facility Name (If not institution, give street and number) 1622 Webster Street				4b. City, Town, or Location of Death Baltimore				4c. County of Death N/A	
Funeral Director	5. Social Security Number 233-56-2565		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 65 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 28 1934		9. Birthplace (State or Foreign Country) West Virginia	
	Usual Residence of Decedent				10a. State Md.		10b. County n/a		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10e. Street and Number 1622 Webster Street				10f. Zip Code 21230				10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: white	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Packer				16b. Kind of Business/Industry Carr' Lowery Glass Company			
	17. Father's Name (First, Middle, Last) Stanley Poling				18. Mother's Name (First, Middle, Maiden Surname) Addie Pifer					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Jimmy Sutherland (Husband)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1622 Webster, Street, Baltimore, Md. 21230					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery				20c. Location - City or Town, State Baltimore, Md.	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 130 E. Fort ave, Baltimore, Md. 21230					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death					
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Breast Cancer, Rectal Cancer, Hypothyroidism								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
									24e. Was an autopsy performed? Inspection 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
									24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input checked="" type="checkbox"/> Other (Specify) at scene					
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
					28d. Describe how injury occurred					
					28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
					28f. Location (Street and Number or Rural Route Number, City or Town, State)					
To Be Completed by Physician/Medical Examiner	29e. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29c. License number O.C.M.E.				29d. Date signed (Month, Day, Year) August 30, 2000	
	29b. Signature and title of certifier 									
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mary G. Ripple, M.D.				111 Penn Street, Baltimore, Maryland 21201					
	31. Date filed (Month, Day, Year) AUG 31 2000				32. Registrar's Signature 					



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State of Maryland / Department of Health and Mental Hygiene

00 27569

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Theodore Smith</b>				2. Date of Death Month <b>Aug.</b> Day <b>27</b> , Year <b>2000</b>		3. Time of Death <b>8:55pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>Good Samaritan Nursing Home</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>NA</b>	
Funeral Director	5. Social Security Number <b>215-14-0760</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>75</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>05-15-25</b>	
	10a. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>401 E. Northern Parkway Apt#2</b>				10f. Zip Code <b>21212</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11th Grade</b> College (1-4 or 5+) <b>NA</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Laborer</b>		16b. Kind of Business/Industry <b>Liberty Cue Club</b>		
17. Father's Name (First, Middle, Last) <b>William Smith</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Clara Pompey</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Austina Smith</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21212</b> <b>410 E. Northern Parkway Apt.#2 Baltimore, MD</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>King Mem. Pk. Cem. 09-01-2000 Randallstown, MD</b>		20c. Location - City or Town, State		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Baltimore, Maryland 21202</b> <b>WM.C.March FH 1101 E. North Avenue</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Cancer Lung</b> Due to (or as a consequence of)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>				Approximate Interval Between Onset and Death <b>More Than 6 Months</b>				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
				28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 		29c. License number <b>D 30661</b>		
				29d. Date signed (Month, Day, Year) <b>August 28, 2000</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>SURESH K. TRIPATHI</b> <b>5601 Loch Raven Blvd. Baltimore, Md - 21239</b>								
31. Date filed (Month, Day, Year) <b>AUG 31 2000</b>				32. Registrar's Signature 				



Patrick J. Smith

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #23 PART I, 27, 28A-F PER MEO G787 9-8-00 WR.

Certificate of Death

Reg. No.

00 27570

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Patrick J. Smith				2. Date of Death Month Day Year August 26 2000		3. Time of Death 10:03 P.M.	
	4a. Facility Name (If not institution, give street and number) North Arundel Hospital				4b. City, Town, or Location of Death Glen Burnie		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 385-68-7212		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 43 Yrs.		8. Date of Birth (Month, Day, Year) 04-12-1957	
	10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Glen Burnie		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Construction Manager		16b. Kind of Business/Industry Construction	
	17. Father's Name (First, Middle, Last) Paul R. Smith				18. Mother's Name (First, Middle, Maiden Surname) Betty Maue			
	19a. Informant's Name/Relationship (Type, Print) Sonia Smith/ Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 902 Oakwood Road Glen Burnie MD 21061			
	20e. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Cremation		20c. Location - City or Town, State Stevensville, MD		20d. Date 08-29 2000	
	21. Signature of Funeral Service Licensed				22. Name and Address of Facility Singleton Funeral Home P.A. 1 Second Ave. S.W. Glen Burnie, MD 21061			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  HYDROXYZINE INTOXICATION a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.				Approximate Interval Between Onset and Death			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
					24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
					24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) 8-26-00		28b. Time of Injury UNKNOWN		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28e. Pending Investigation <input type="checkbox"/> Could not be determined <input type="checkbox"/>		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) HOME		28f. Location (Street and Number or Rural Route Number, City or Town, State) 902 OAKWOOD RD. GLEN BURNIE, MD				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) August 28, 2000		
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. A. Fox, MD 111 Penn Street, Baltimore, Maryland 21201							
	31. Date filed (Month, Day, Year) AUG 31 2000				32. Registrar's Signature 			

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27571

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Charles E. Snowden

2. Date of Death

August 29 2000

3. Time of Death

2:59pm

4a. Facility Name (If not institution, give street and number)

DOCTORS COMMUNITY HOSPITAL

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince Georges

Funeral  
Director

5. Social Security Number

213-52-4810

6. Sex

M ☒ F

7. Age (In yrs. last birthday)

50 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct. 22, 1949

9. Birthplace (State and Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Prince Georges

10c. City, Town or Location

Upper Marlboro

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

300 Ridgely Court

10f. Zip Code

20774

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married  
☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☒ Yes ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: african american

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Long Shoreman

16b. Kind of Business/Industry

Steamship Trade

17. Father's Name (First, Middle, Last)

Theodore Snowden Sr.

18. Mother's Name (First, Middle, Maiden Surname)

St. Louise Haley

19a. Informant's Name/Relationship (Type, Print)

Yvonne V. Williams SISTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

300 Ridgely Ct. Upper Marlboro MD 20774

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lake Mont Memorial

Date

9/6/00

20c. Location - City or Town, State

Davidsonville, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Wyle Funeral Home PA  
638 N. Sumner St. Baltz. MD 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

SARCROIDOSIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

YEARS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HEPATIC FAILURE

CONGESTIVE HEART FAILURE

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural  
☐ Accident  
☐ Suicide  
☐ Homicide☐ Pending investigation  
☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] M.D.

29c. License number

D47604

29d. Date signed (Month, Day, Year)

8/30/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SOBHAN MATHEN MD, 2905 MITCHELLVILLE RD #104, BOWIE, MD 20716

State  
Registrar

31. Date filed (Month, Day, Year)

AUG 31 2000

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

00 27572

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Charles J. Sanders, Sr.

2. Date of Death

August 27, 2000

3. Time of Death

3:50 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Stella Maris

4b. City, Town, or Location of Death

Timonium

4c. County of Death

Baltimore

5. Social Security Number

212-20-8185

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Mar 1, 1926

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10 Queen Anne Road

10f. Zip Code

21061

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
5

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Shipping Supervisor

16b. Kind of Business/Industry

Wholesale Vending

17. Father's Name (First, Middle, Last)

Edward L. Sanders

18. Mother's Name (First, Middle, Maiden Surname)

Emma Haugh

19a. Informant's Name/Relationship (Type, Print)

William E. Sanders / son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6376 Greenfield Road, Elkridge, Maryland 21075

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Loudon Park Cemetery

Date

8/31/2000 Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Hubbard Funeral Home, Inc.

4107 Wilkens Avenue, Baltimore, Maryland 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. MULTIPLE MYELOMA

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) HOSPICE

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of Certifier

29c. License number

D43725

29d. Date signed (Month, Day, Year)

8/29/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

State  
Registrar

31. Date filled (Month, Day, Year)

AUG 31 2000

32. Registrar's Signature

ORIGINAL

AUGUST 27, 2000 3:50 p.m.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
202-358-2000.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

CHARLES SANDERS

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Belzora  
Saunders

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State of Maryland / Department of Health and Mental Hygiene

Amended item#23a part 1 per ME G787 9-1-00 WJJ

Certificate of Death

Reg. No. 00 27573

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Belzora Saunders</i>				2. Date of Death Month Day Year <i>AUGUST 26 2000</i>		3. Time of Death <i>4:30 P.M.</i>	
	4a. Facility Name (If not institution, give street and number) <i>Noble House</i>				4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>NA</i>	
Funeral Director	5. Social Security Number <i>213-16-5972</i>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>92</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>October 18, 1907</i>		9. Birthplace (State or Foreign Country) <i>SC</i>
	Usual Residence of Decedent				10a. State <i>MD</i>		10b. County <i>NA</i>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number <i>201 N. Washington St.</i>		10f. Zip Code <i>21231</i>	
	10g. Citizen of What Country? <i>USA</i>				11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <i>African American</i>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12th</i> College (1-4 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Domestic</i>				16b. Kind of Business/Industry <i>Homes</i>		17. Father's Name (First, Middle, Last) <i>Henry Woods</i>	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) <i>Mary Woods</i>				19a. Informant's Name/Relationship (Type, Print) <i>Theodore T. Carter God-Son</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>700 Chapel Gate Lane Balt. MD 21229</i>	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Not Prospect Blc cemetery</i>		20c. Location - City or Town, State <i>8/31/01 Chester County, Chester</i>	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licenses <i>[Signature]</i>				22. Name and Address of Facility <i>Wylie Funeral Home PA 635 N. Guilford St Baltimore, MD 21217</i>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <i>CHRONIC RENAL FAILURE</i> Due to (or as a consequence of): Renal Cell Carcinoma  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. { Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
To Be Completed by Physician/Medical Examiner	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No				28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
	28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <i>D16619</i>		29d. Date signed (Month, Day, Year) <i>August 28, 2000</i>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>C. VERGARA-SOARES 2327 N. CHARLES ST. BALTIMORE, MD. 21218</i>				31. Date filed (Month, Day, Year) <i>AUG 30 2000</i>			
To Be Completed by Physician/Medical Examiner	32. Registrar's Signature <i>[Signature]</i>				33. State Registrar			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,







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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27574

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Frank L. Staron, Sr.

2. Date of Death  
Month Day Year

AUGUST 24, 2000

3. Time of Death

1:10 A.M.

4a. Facility Name (If not institution, give street and number)

FRANKLIN SQUARE HOSPITAL CENTER

4b. City, Town, or Location of Death

ROSEDALE

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

371-14-0714

6. Sex

15 M 2 F

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Feb. 27, 1920

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

6918 Ridgeway Road

10f. Zip Code

21222

10g. Citizen of What Country?

United States

11. Marital Status

1 Never Married 2 Married  
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 Yes 2 No  
If Yes, Give  
Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12 Years

College (1-4 or 5+)

1 Year

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Steelworker

16b. Kind of Business/Industry

Steel Industry

17. Father's Name (First, Middle, Last)

John Staron

18. Mother's Name (First, Middle, Maiden Surname)

Caroline Lawrence

19a. Informant's Name/Relationship (Type, Print)

Mr. Frank L. Staron, Jr. (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15 Tamarack Trail Baltimore, MD 21220

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State  
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Meadowridge Mem. Park 8/26/2000

Date

20c. Location - City or Town, State

Elkridge, Maryland

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.

7922 Wise Ave.. Dundalk, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. RESPIRATORY FAILURE

Due to (or as a consequence of):

b. METASTASIS OF CANCER

Due to (or as a consequence of):

c. LUNG CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient

2 ER/Outpatient

3 DOA

26. Place of Death (Check only one)

Other:

4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 5 Pending Investigation  
2 Accident 6 Could not be determined  
3 Suicide  
4 Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated  
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*[Signature]* MD

29c. License number

RD 203323

29d. Date signed (Month, Day, Year)

AUGUST 24, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SANJUL VARGHESE, MD, 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237

31. Date filed (Month, Day, Year)

AUG 31 2000

32. Registrar's Signature

*[Signature]*

State  
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

State Registrar

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

00 27575

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Elsie Szeto</b>				2. Date of Death Month Day Year <b>August 25, 2000</b>		3. Time of Death <b>15:11 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Union Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>114-48-0840</b>		8. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) <b>79</b>	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Jan. 27, 1921</b>	
	9. Birthplace (State or Foreign Country) <b>Hong Kong</b>							
To Be Completed by Funeral Director	Usual Residence of Decedent							
	10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Parkville</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <b>8800 Walther Blvd. Apt. 3421</b>				10f. Zip Code <b>21234</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Oriental</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Bank Teller</b>		16b. Kind of Business/Industry <b>Banking</b>	
	17. Father's Name (First, Middle, Last) <b>Yeetung Woo</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>B.L. Wong</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Onward Szeto/ Husband</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8800 Walther Blvd. Apt. 3421 Baltimore MD 21234</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Rose Hill Memorial Park</b>		20c. Location - City or Town, State <b>Whittier CA</b>		20d. Date <b>9/2/2000</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>John C. Miller, Inc. 6415 Belair Road Baltimore MD 21206</b>			
	23a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. Cardiogenic Shock</b> Due to (or as a consequence of): <b>b. coronary artery disease</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b> Approximate Interval Between Onset and Death <b>3 days</b> <b>10 years</b>							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>peripheral vascular disease</b> <b>acute renal failure</b>								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier <b>Peter J. Sloane MD, medical Attending MD</b>				29c. License number <b>D41543 (Maryland)</b>		29d. Date signed (Month, Day, Year) <b>August 25, 2000</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Peter J Sloane, MD 3333 N Calvert St #650 Baltimore MD 21218</b>							
	31. Date filed (Month, Day, Year) <b>AUG 31 2000</b>		32. Registrar's Signature 					

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27576

AMENDED ITEMS 29c, 29d PER MD G786 8/31/00 AH

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Ruben Elmer Satchell Jr</i>				2. Date of Death Month <i>August</i> Day <i>20</i> Year <i>2000</i>		3. Time of Death <i>6:30 AM</i>	
	4a. Facility Name (If not institution, give street and number) <i>University of Maryland Medical Systems Baltimore</i>				4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>N/A</i>	
Funeral Director	5. Social Security Number <i>222-40-0955</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <i>46</i> Yrs. <input type="checkbox"/> Under 1 Year <input type="checkbox"/> Under 24 Hrs.		8. Date of Birth (Month, Day, Year) <i>May 7, 1954</i>	
	9. Birthplace (State or Foreign Country) <i>DE</i>							
Usual Residence of Decedent								
10a. State <i>DE</i>		10b. County <i>Sussex</i>		10c. City, Town or Location <i>Milton</i>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <i>Route 1 Box 68-A</i>				10f. Zip Code <i>19968</i>		10g. Citizen of What Country? <i>United States</i>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>11</i> College (1-4 or 5+) <i>11</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Laborer</i>		16b. Kind of Business/Industry <i>Farm</i>		
17. Father's Name (First, Middle, Last) <i>Ruben Elmer Satchel, Sr.</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Mary E. Tingle</i>				
19a. Informant's Name/Relationship (Type, Print) <i>Juanita Y. Wiltbank-Sister</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>203 Apollo Lane Milton, DE 19969</i>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Old Hickory Cemetery</i>		Date <i>Aug 26 2000</i>		20c. Location - City or Town, State <i>Slaughter Neck, DE</i>
21. Signature of Funeral Service Licensee <i>Calvin L. U...</i>				22. Name and Address of Facility <i>Smith &amp; Williams Funeral Home, P.A. 2818 East Baltimore Street Baltimore, MD</i>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
Immediate Cause (Final disease or condition resulting in death)		a. <i>Brainstem Herniation</i>						Approximate Interval Between Onset and Death <i>hours</i>
		Due to (or as a consequence of):						
		b. <i>Tuberculosis infection</i>						<i>days</i>
		Due to (or as a consequence of):						
		c. <i>Acute Renal Failure</i>						<i>days</i>
		Due to (or as a consequence of):						
		d. <i>Massive gastrointestinal bleed</i>						
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
			28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>Leslie Bellosso Resident physician</i>				29c. License number <i>13117</i>		29d. Date signed (Month, Day, Year) <i>AUGUST 22, 2000</i>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Leslie Bellosso MD, 22 South Greene Street, Baltimore, Maryland 21201</i>								
31. Date filed (Month, Day, Year) <i>AUG 31 2000</i>			32. Registrar's Signature <i>B Sparks</i>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at 2025.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





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State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #23 PART I, 27 PER ME

G787 96-00 WR. 9-6-00 00

Reg. No.

27577

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Cheryl Ann Schmidt

2. Date of Death

August 25, 2000

3. Time of Death

7:13 P.M.

4a. Facility Name (If not institution, give street and number)

7842 Belair Road

4b. City, Town, or Location of Death

Fullerton

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

217-70-5499

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

43

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

1/16/1957

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Fullerton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7842 Belair Road

10f. Zip Code

21236

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Nurse

16b. Kind of Business/Industry

Temp

17. Father's Name (First, Middle, Last)

Harry J. Fiddesop Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Ruth Smith

19a. Informant's Name/Relationship (Type, Print)

Sean Schmidt/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

506 Hillen Road Towson, Maryland 21286

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cheasapeake Crematory

Date

8/31/00 Laurel, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

John C. Miller Inc.

6415 Belair Road Baltimore, Maryland 21206

23a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

ACUTE CORONARY ARTERY THROMBOSIS DUE TO  
HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☒ Other (Specify)

at scene

27. Manner of Death

1 ☐ Natural  
2 ☐ Accident  
3 ☐ Suicide  
4 ☐ Homicide5 ☒ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician2 ☒ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

August 26, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mary G. Ripple, M.D.

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

AUG 31 2000

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at 800-555-5555.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27578

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>SALLIE ANN THORNTON</b>				2. Date of Death Month <b>August</b> Day <b>24</b> Year <b>2000</b>		3. Time of Death <b>1:45pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>AUGSBURG LUTHERAN NURSING HOME</b>				4b. City, Town, or Location of Death <b>LOCHERN</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>216 20 2506</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>90</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>March 20, 1910</b>		9. Birthplace (State or Foreign Country) <b>N. Carolina</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>3925 FAIRVIEW AVE</b>				10f. Zip Code <b>21216</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>1 year</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>LPN</b>		16b. Kind of Business/Industry <b>Private Duty</b>		
17. Father's Name (First, Middle, Last) <b>Jerry Mc CLAIN</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>CARA HOLLAND</b>				
19a. Informant's Name/Relationship (Type, Print) <b>James McDonald / son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4802 Olney Road Baltimore, Maryland 21215</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>Extantment</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ARATUS MEMORIAL Park</b>		Date <b>8/30/2000</b>		20c. Location - City or Town, State <b>Arbutus, Maryland</b>		
21. Signature of Funeral Service Licensee <b>[Signature]</b>				22. Name and Address of Facility <b>CNATHAN - Harris Funeral Home 5240 REISTERSTOWN ROAD BALTIMORE, MD 21215</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. END STAGE CONGESTIVE CARDIOMYOPATHY</b> Due to (or as a consequence of): <b>b. CORONARY ARTERY DISEASE</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>								
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ALZHEIMER DEMENTIA</b>								
23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <b>[Signature]</b>				29c. License number <b>1145931</b>		29d. Date signed (Month, Day, Year) <b>August 24, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Deborah I Pierce 7220 PARLITEIGHTS AVE BALTIMORE, MD 21208</b>								
31. Date filed (Month, Day, Year) <b>AUG 31 2000</b>				32. Registrar's Signature <b>[Signature]</b>				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27579

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>WILLIAM OSCAR TURNER</b>				2. Date of Death Month <b>AUGUST</b> Day <b>29</b> , Year <b>2000</b>		3. Time of Death <b>7:45 PM</b>	
	4a. Facility Name (If not Institution, give street and number) <b>GENESIS ELDERCARE CROMWELL</b>				4b. City, Town, or Location of Death <b>TOWSON</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>214-22-3103</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>97</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>5/1/03</b>	
	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>		10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE CITY</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number <b>4210 HECKEL AVENUE</b>		10f. Zip Code <b>21206</b>	
	10g. Citizen of What Country? <b>USA</b>				11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8TH GRADE</b> College (1-4 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SUPERINTENDENT</b>				16b. Kind of Business/Industry <b>JOHNS HOPKINS HOSPITAL</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>WILLIAM O. TURNER</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>MARY JANE WILLIAMS</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>IRMA WOLBERT DAUGHTER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>203 CROSSE POINTE COURT #2B Abingdon, MD 21009</b>			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>METRO CREMATORY, INC.</b>		20c. Location - City or Town, State <b>CATONSVILLE, MD</b>	
	21. Signature of Funeral Service Licensee <i>Heath N. Hay</i>				22. Name and Address of Facility <b>THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286</b>			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Ischemic Heart Disease</b> Due to (or as a consequence of): <b>b. Hypertension</b> Due to (or as a consequence of): <b>c. Chronic Obstructive Lung Disease</b> Due to (or as a consequence of): <b>d.</b>				Approximate Interval Between Onset and Death			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No				28d. Describe how injury occurred			
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>Ziad Mirza MD</i>			
To Be Completed by Physician/Medical Examiner	29c. License number <b>041901</b>				29d. Date signed (Month, Day, Year) <b>8-30-2000</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Ziad Mirza MD, 3007 G Northern Parkway, Baltimore, MD 21214</b>				31. Date filed (Month, Day, Year) <b>AUG 31 2000</b>			
To Be Completed by Physician/Medical Examiner	32. Registrar's Signature <i>Bernard P. Sparks</i>				33. State Registrar <b>AUG 31 2000</b>			
	34. State Registrar <b>AUG 31 2000</b>				35. State Registrar <b>AUG 31 2000</b>			

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27580

HARVEY TEMPLE 4:00 PM 26 AUGUST 2000

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23d show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Harvey Temple, Jr.</b>		2. Date of Death Month Day Year <b>August 26, 2000</b>		3. Time of Death <b>4:00 a.m.</b>		
4a. Facility Name (If not institution, give street and number) <b>Joseph Richie Hospice</b>			4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>n/a</b>	
5. Social Security Number <b>213-12-2544</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>80</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>March 2, 1920 Md.</b>	
Usual Residence of Decedent						
10a. State <b>Md.</b>	10b. County <b>n/a</b>	10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>2911 Chelsea Terrace</b>		10f. Zip Code <b>21216</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		
14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>						
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4th Grade</b> College (1-4or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Longshoreman</b>		16b. Kind of Business/Industry <b>I.L.A.-S. T. A.</b>	
17. Father's Name (First, Middle, Last) <b>Harvey Temple, Sr.</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Bessie Hughes</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Jean Nelson</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Daughter 2911 Chelsea Terrace Baltimore, Md. 21216</b>				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arbutus Memorial Park</b>		Date <b>Aug. 31</b>	20c. Location - City or Town, State <b>Baltimore, Md.</b>	
21. Signature of Funeral Service Licensee <b>Herbert E. Nutter</b>		22. Name and Address of Facility <b>Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Carcinoma of pancreas</b> Due to (or as a consequence of): <b>b. Metastases</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>c.</b> Due to (or as a consequence of):  <b>d.</b> Due to (or as a consequence of):					Approximate Interval Between Onset and Death <b>6 mo</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Pneumonia</b>					23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
					24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury <b>M</b>	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
29b. Signature and Title of certifier <b>John W. Payne</b>		29c. License number <b>00013012</b>		29d. Date signed (Month, Day, Year) <b>26 Aug 00</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>John Payne 6565 N. Charles St. Bkto 21204</b>						
31. Date filed (Month, Day, Year) <b>AUG 31 2000</b>		32. Registrar's Signature <b>Sparks</b>				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27581

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) James Fred Thorne Jr.				2. Date of Death Month Day Year AUGUST 29, 2000				3. Time of Death 05:44 PM	
	4a. Facility Name (If not institution, give street and number) MEMORIAL HOSPITAL				4b. City, Town, or Location of Death CUMBERLAND				4c. County of Death ALLEGANY	
Funeral Director	5. Social Security Number 232-06-9596		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 39 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) Aug 18, 1961		9. Birthplace (State or Foreign Country) VA		10a. State WV		10b. County Hampshire		10c. City, Town or Location Capon Bridge	
Usual Residence of Decedent										
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
10e. Street and Number HC-71 Box 107					10f. Zip Code 26711			10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) trucker			16b. Kind of Business/Industry trucking		
17. Father's Name (First, Middle, Last) James Fred Thorne Sr.					18. Mother's Name (First, Middle, Maiden Surname) Elma M. Eaton					
19a. Informant's Name/Relationship (Type, Print) James F. Thorne Sr. (father)					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HC-71 Box 107 Capon Bridge, WV 26711					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Old Mt. Union Cemetery			Date 9-1-2000		20c. Location - City or Town, State Paw Paw, WV		
21. Signature of Funeral Service Licensee ▶ <u>Page Haight Herbert</u>					22. Name and Address of Facility Haight Funeral Home & Chapel P.O. Box 195 Sykesville, Md 21784					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <u>Compressional asphyxia and chest injuries</u> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last										
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year) 8-29-2000		28b. Time of Injury 4:00 PM		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred. subject was working under truck when it rolled on top of him	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Parent's House										
28f. Location (Street and Number or Rural Route Number, City or Town, State) HC 71, Box 107 Capon Bridge, West Virginia										
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier ▶ <u>Stephen S. Radentz, M.D.</u>					29c. License number OCME			29d. Date signed (Month, Day, Year) AUGUST 30, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201										
31. Date filed (Month, Day, Year) AUG 31 2000					32. Registrar's Signature <u>Benjamin S. Sparks</u>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23d show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27582

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Earl Emory Uhlfelder				2. Date of Death Month August Day 31 Year 2000		3. Time of Death 1:00 AM	
	4a. Facility Name (If not institution, give street and number) 13013 Gent Road				4b. City, Town, or Location of Death Reisterstown		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 213-03-7980		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) January 8 1917	
	9. Birthplace (State or Foreign Country) Maryland							
Usual Residence of Decedent								
10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number 5501 Sagra Road				10f. Zip Code 21239		10g. Citizen of What Country? United States		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Salesman			16b. Kind of Business/Industry Insurance	
17. Father's Name (First, Middle, Last) Joseph J. Uhlfelder				18. Mother's Name (First, Middle, Maiden Surname) Ethel Louise Tucker				
19a. Informant's Name/Relationship (Type, Print) Thomas E. Uhlfelder (Son)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13013 Gent Road Reisterstown, Maryland 21136				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Green Mount Crematory		20c. Location - City or Town, State Baltimore, Maryland		Date 9/6/00
21. Signature of Funeral Service Licensee Steven T. Felt				22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212				
23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</u> YEARS Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <u>SON'S RESIDENCE</u>				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29e. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier F. P. Williams MD				29c. License number D11171		29d. Date signed (Month, Day, Year) August 31, 2000		
30. Name and address of person who completed cause of death (Per 23a) (Type, Print) F. P. Williams MD 405 FREDERICK RD CATONSVILLE 21228 MARYLAND								
31. Date filed (Month, Day, Year) AUG 31 2000		32. Registrar's Signature Benjamin Sparks						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

11

*[Signature]*  
B. W. 9



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27583

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

John

2. Date of Death

Month Day Year  
Aug. 29 2000

3. Time of Death

2:45PM

4a. Facility Name (If not institution, give street and number)

Good Samaritan Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

150-01-5934

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
April 12, 1918

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore Co.

10c. City, Town or Location

Perry Hall

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5 Horn Point Court

10f. Zip Code

21234

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 1942-1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Millwright

16b. Kind of Business/Industry

Chemical

17. Father's Name (First, Middle, Last)

Joseph Velcheck

18. Mother's Name (First, Middle, Maiden Surname)

Rose Cork

19a. Informant's Name/Relationship (Type, Print)

Mrs. Isabel M. Velcheck / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5 Horn Point Court Baltimore, Maryland 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Joseph Cemetery

Date

9/2/00

20c. Location - City or Town, State

Bridgewater, New Jersey

21. Signature of Funeral Service Licensee

Michael E. Canapp  
Michael E. Canapp

22. Name and Address of Facility

5305 Harford Road  
Leonard J. Ruck, Inc. Baltimore, MD 21214

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 day

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Sepsis

Due to (or as a consequence of):

1 day

c. pneumonia

Due to (or as a consequence of):

1 day

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Attending Physician

29c. License number

D53642

29d. Date signed (Month, Day, Year)

Aug. 29 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

X/O 2 HESU 3007 E Northern Parkway Baltimore 21214

31. Date filed (Month, Day, Year)

AUG 31 2000

32. Registrar's Signature

Beverly B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27584

Amended item# 10c per FH G786 8-31-00WJJ

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) James Wall				2. Date of Death Month Day Year August 29, 2000				3. Time of Death 7:20 P.M.	
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick				4c. County of Death Frederick	
Funeral Director	5. Social Security Number 151-10-9362	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 07 31 1912		9. Birthplace (State or Foreign Country) NJ		
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State N.J.	10b. County Hudson	10c. City, Town or Location Bayonne				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number 9 West 42nd Street				10f. Zip Code 07002		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Painter				16b. Kind of Business/Industry School System			
	17. Father's Name (First, Middle, Last) Thomas Wall				18. Mother's Name (First, Middle, Maiden Surname) Ellen Cavanaugh					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Ellen Smith/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17 West 42nd St. Bayonne, NJ 07002					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Holy Name Cemetery		Date 09 02		20c. Location - City or Town, State Jersey City, N.J.			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Sterling-Ashton-Schwab Funeral Home, Inc 736 Edmonson Avenue, Balto., Md. 21228					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>a. <u>Pneumonia</u> Due to (or as a consequence of):</p> <p>b. <u>Dementia of Alzheimer type</u> Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____ Due to (or as a consequence of):</p> </div> <div style="width: 35%;"> <p>Approximate Interval Between Onset and Death</p> <p>days</p> <p>months</p> </div> </div>									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Chronic obstructive Pulmonary Disease, emphysema, Anorexia</u> <u>chronic renal failure, Anemia, s/p pacemaker placement</u>								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 				29c. License number D47169		29d. Date signed (Month, Day, Year) 8/30/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ho Chan-hing 610 9th Ave, Brunswick, MD 21716										
31. Date filed (Month, Day, Year) AUG 31 2000		32. Registrar's Signature 								

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27585

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Marshall Dunbar Waters				2. Date of Death August 23, 2000		3. Time of Death 5:34 PM	
	4a. Facility Name (If not institution, give street and number) Sinai Hospital of Baltimore				4b. City, Town, or Location of Death Baltimore		4c. County of Death n/a	
Funeral Director	5. Social Security Number 219-05-3012	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Nov. 29, 1919		9. Birthplace (State or Foreign Country) Md.
	Usual Residence of Decedent							
10a. State Md.		10b. County Baltimore		10c. City, Town or Location Lochearn		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 7904 Dunhill Village Circle #301				10f. Zip Code 21244		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Porter		16b. Kind of Business/Industry Koppers Company		
17. Father's Name (First, Middle, Last) unknown				18. Mother's Name (First, Middle, Maiden Surname) unknown				
19a. Informant's Name/Relationship (Type, Print) Frances R. Waters wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7904 Dunhill Village Circle #301 Lochearn, Md. 21244				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory		20c. Location - City or Town, State Aug. 29 Baltimore, Md.		
21. Signature of Funeral Service Licensee Herbert E. Nutter				22. Name and Address of Facility Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cardiopulmonary failure Due to (or as a consequence of): Cancer of duodenum Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
		28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier M. S. Didolkar MD		29c. License number D 22105		29d. Date signed (Month, Day, Year) 8/24/2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. S. DIDOLKAR MD SINAI HOSP BALTIMORE MD 21215								
31. Date filed (Month, Day, Year) AUG 31 2000		32. Registrar's Signature B. Sparks						

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27586

amend item 6,7 per fh G787 9/5/00 yf

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>William Eugene Walker</i>				2. Date of Death Month <i>Aug</i> Day <i>28</i> Year <i>2000</i>		3. Time of Death <i>9:55 AM</i>	
	4a. Facility Name (If not institution, give street and number) <i>Snai Hospital of Balt.</i>				4b. City, Town, or Location of Death <i>Baltimore, MD</i>		4c. County of Death <i>Baltimore County</i>	
Funeral Director	5. Social Security Number <i>218-09-2834</i>		6. Sex <input checked="" type="radio"/> M <input type="radio"/> F		7. Age (In yrs. last birthday) <i>92</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>1/14/1908</i>	
	9. Birthplace (State or Foreign Country) <i>Md.</i>		10a. State <i>Md.</i>		10b. County <i>n/a</i>		10c. City, Town or Location <i>Baltimore</i>	
Usual Residence of Decedent				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
10e. Street and Number <i>3801 Loch Raven BLVD</i>				10f. Zip Code <i>21218</i>		10g. Citizen of What Country? <i>USA</i>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12th Grade</i> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Postal Worker</i>		16b. Kind of Business/Industry <i>US Postal Service</i>		
17. Father's Name (First, Middle, Last) <i>Josiah Walker</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Alma Isbell</i>				
19a. Informant's Name/Relationship (Type, Print) <i>Alma Walker-Brown daughter</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3801 Loch Raven BLVD Baltimore, Md. 21218</i>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Garrison Forrest Veterans Sept. 6 Owings Mills, Md.</i>		20c. Location - City or Town, State				
21. Signature of Funeral Service Licensee <i>Herbert E. Nutter</i>				22. Name and Address of Facility <i>Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216</i>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Sepsis</i> Due to (or as a consequence of): <i>MRSA - Endocarditis</i> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <i>MRSA - Endocarditis</i> Due to (or as a consequence of): <i>Sepsis</i> Due to (or as a consequence of):								Approximate Interval Between Onset and Death <i>24</i>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Anoxic Encephalopathy Severe Aortic Stenosis</i>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>Stachell M.D.</i>				29c. License number <i>RES000</i>		29d. Date signed (Month, Day, Year) <i>8/28/2000</i>		
30. Name and Address of person who completed cause of death (Item 23e) (Type, Print) <i>Steven Hamlette 2401 W. Belvedere Baltimore, MD 21215</i>								
31. Date filed (Month, Day, Year) <i>AUG 31 2000</i>		32. Registrar's Signature <i>Sparks</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e-I show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27587

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>GUYVOR WORRELL</b>				2. Date of Death Month <b>August</b> Day <b>29</b> Year <b>2000</b>		3. Time of Death <b>8:08 a.m.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Harbor Hospital Center</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>n/a</b>	
Funeral Director	5. Social Security Number <b>217-18-6327</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>88</b>		8. Date of Birth (Month, Day, Year) <b>Jan. 25, 1912</b>	
	9. Birthplace (State or Foreign Country) <b>Va.</b>		10a. State <b>Md.</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Pasadena</b>	
Usual Residence of Decedent								
10e. Street and Number <b>8106 Hogneck Road Apt. T</b>				10f. Zip Code <b>21122</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th Grade</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>House Wife</b>			16b. Kind of Business/Industry <b>Self-Employed</b>	
17. Father's Name (First, Middle, Last) <b>Julius Brown</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Jeanett Worrell</b>				
19a. Informant's Name/Relationship (Type, Print) <b>James Williams Great Grandson</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8106 Hogneck Road Pasadena, Md. 21122</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cedar Hill Cemetery</b>			20c. Location - City or Town, State <b>Sept. 1 Brooklyn, Md.</b>		
21. Signature of Funeral Service Licensee <b>Herbert E. Nutter</b>				22. Name and Address of Facility <b>Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>Sepsis</b> Due to (or as a consequence of):  b. <b>Aspiration Pneumonia</b> Due to (or as a consequence of):  c. <b>DIC due to Sepsis</b> Due to (or as a consequence of):  d. <b>Hyperosmolality due to Diabetes</b>								Approximate Interval Between Onset and Death  <b>2-3 days</b>  <b>12 hours</b>  <b>12 hours</b>  <b>2 Days</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes Melitus</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <b>Kouroush Dibadj, MD, Resident</b>				29c. License number <b>Res 001</b>		29d. Date signed (Month, Day, Year) <b>August 29, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>KOURUSH DIBADJ, 3001 South Hanover Street, Baltimore, MD 21225</b>								
31. Date filed (Month, Day, Year) <b>AUG 31 2000</b>				32. Registrar's Signature <b>[Signature]</b>				

Baltimore, Maryland 21215-0020

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27588

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>BELINDA WISE</b>				2. Date of Death Month <b>AUGUST</b> Day <b>30</b> Year <b>2000</b>				3. Time of Death <b>12:55 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Bon Secours Hospital</b>				4b. City, Town, or Location of Death <b>Balto.</b>				4c. County of Death <b>N/A</b>		
Funeral Director	5. Social Security Number <b>220-64-2949</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>30</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		
	8. Date of Birth (Month, Day, Year) <b>OCT 27, 1969</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>MD.</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>		
Usual Residence of Decedent											
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No											
10e. Street and Number <b>1002 N. Mount St.</b>				10f. Zip Code <b>21217</b>				10g. Citizen of What Country? <b>U.S.A.</b>			
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9th</b> College (1-4or 5+)				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>telemarketer</b>				16b. Kind of Business/Industry <b>telemarketing</b>			
17. Father's Name (First, Middle, Last) <b>Antonio Wise</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lamour Griffin</b>							
19e. Informant's Name/Relationship (Type, Print) <b>Lamour Griffin Washington</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>706 E. Biddle St. Balto. Md. 21202</b>							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Zion Cem.</b>				Date <b>9-6-2000</b>		20c. Location - City or Town, State <b>Balto. Md.</b>	
21. Signature of Funeral Service Licensee <b>Carlton C. Douglass</b>				22. Name and Address of Facility <b>Carlton C. Douglass Funeral Service 1701 McCulloch St. Balto. Md. 21211</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
Immediate Cause (Final disease or condition resulting in death)											
a. <b>Bilateral PNEUMONIA</b>											
Due to (or as a consequence of):											
b. <b>END Stage Acquired IMMUNODEFICIENCY syndrome</b>											
Due to (or as a consequence of):											
c.											
Due to (or as a consequence of):											
d.											
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown											
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier <b>Terance Lamb MD</b>				29c. License number <b>D37203</b>				29d. Date signed (Month, Day, Year) <b>AUGUST 30 2000</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>TERANCE LAMB MD Bon Secours Hospital, Baltimore MD 21223</b>											
31. Date filed (Month, Day, Year) <b>AUG 31 2000</b>				32. Registrar's Signature <b>Terance Lamb</b>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27589

amend item 8 per fh G787 9/1/00 yf

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Col. Clarence William White				2. Date of Death Month Day Year August 27, 2000		3. Time of Death 1:00 PM	
	4a. Facility Name (If not institution, give street and number) Hospice of Baltimore, Gilchrist Center				4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 218-05-3379	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Oct. 13, 1918	9. Birthplace (State or Foreign Country) Md.	
	Usual Residence of Decedent							
10a. State Md.		10b. County Baltimore		10c. City, Town or Location Baltimore		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 6513 Sharon Rd.				10f. Zip Code 21239		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WW-II		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 5+				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Construction Engineer		16b. Kind of Business/Industry State of Maryland Military Department		
17. Father's Name (First, Middle, Last) Charles Stewart White				18. Mother's Name (First, Middle, Maiden Surname) Blanche Macey				
19a. Informant's Name/Relationship (Type, Print) Mrs. Catherine S. White/wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6513 Sharon Rd. Baltimore, Md. 21239				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery		Date 8/31/00		20c. Location - City or Town, State Parkville, Md.		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. metastatic adenocarcinoma Due to (or as a consequence of): b. of unknown primary site Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Approximate Interval Between Onset and Death 3 months								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number D25205		29d. Date signed (Month, Day, Year) August 28, 2000		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) W.A. Riley GPMC 6701 N Charles St. Balto. Md 21204								
31. Date filed (Month, Day, Year) AUG 31 2000		32. Registrar's Signature 						

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27590

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) William F. Wossowski Sr.				2. Date of Death Month Day Year August 28 2000		3. Time of Death 11:50 AM		
	4a. Facility Name (If not institution, give street and number) Mariner Health of Forest Hill				4b. City, Town, or Location of Death Forest Hill		4c. County of Death Harford		
Funeral Director	5. Social Security Number 213-03-3959		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 90 Yrs.		8. Date of Birth (Month, Day, Year) March 26, 1910		
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore		
Usual Residence of Decedent		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 6401 Loch Raven Blvd. Apt. 728		10f. Zip Code 21239		10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Machinist		16b. Kind of Business/Industry Koppers Company					
17. Father's Name (First, Middle, Last) William F. Wossowski				18. Mother's Name (First, Middle, Maiden Surname) Mary Tarlton					
19a. Informant's Name/Relationship (Type, Print) William F. Wossowski Jr.				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1631 Dulaney Drive Jarrettsville, Maryland 21084					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery		Date 8/31/00		20c. Location - City or Town, State Baltimore, Maryland			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. <u>metastatic lung cancer</u> Due to (or as a consequence of):		b. Due to (or as a consequence of):		c. Due to (or as a consequence of):		d. Due to (or as a consequence of):	
23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number D32277		29d. Date signed (Month, Day, Year) August 29, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David S. Duggan 65 W. MacPhail		31. Date filed (Month, Day, Year) AUG 31 2000		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27591

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Dorothy Healdhall</i>				2. Date of Death Month <i>8</i> / Day <i>27</i> / Year <i>00</i>		3. Time of Death <i>5:45 AM</i>														
	4a. Facility Name (If not institution, give street and number) <i>Edenwald</i>				4b. City, Town, or Location of Death <i>Towson</i>		4c. County of Death <i>Baltimore</i>														
Funeral Director	5. Social Security Number <i>216-01-5471</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>88</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>November 24, 1911</i>														
	10a. State <i>Maryland</i>		10b. County <i>Baltimore</i>		10c. City, Town or Location <i>Towson</i>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No														
Usual Residence of Decedent																					
10e. Street and Number <i>800 Southerly Road</i>				10f. Zip Code <i>21286</i>		10g. Citizen of What Country? <i>USA</i>															
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>White</i>														
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>College</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Administrator</i>		16b. Kind of Business/Industry <i>Automotive</i>															
17. Father's Name (First, Middle, Last) <i>Henry Herbert Duval</i>					18. Mother's Name (First, Middle, Maiden Surname) <i>Ada Claire Miller</i>																
19a. Informant's Name/Relationship (Type, Print) <i>J. Donald Rector Nephew</i>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>612 Kingston Road Baltimore, Maryland 21212</i>																
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Lorraine Park Cemetery</i>		20c. Location - City or Town, State <i>Baltimore, Maryland</i>															
21. Signature of Funeral Service Licensee <i>Dennis Sheehan Kunkin</i>				22. Name and Address of Facility <i>Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212</i>																	
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																					
<table border="0"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td><i>chronic obstructive pulmonary disease</i></td> <td><i>10 yrs</i></td> </tr> <tr> <td>b.</td> <td><i>dehydration / malnutrition</i></td> <td><i>2 mos</i></td> </tr> <tr> <td>c.</td> <td><i>alcoholic disease</i></td> <td><i>10 yrs</i></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table>									Immediate Cause (Final disease or condition resulting in death)	a.	<i>chronic obstructive pulmonary disease</i>	<i>10 yrs</i>	b.	<i>dehydration / malnutrition</i>	<i>2 mos</i>	c.	<i>alcoholic disease</i>	<i>10 yrs</i>	d.		
Immediate Cause (Final disease or condition resulting in death)	a.	<i>chronic obstructive pulmonary disease</i>	<i>10 yrs</i>																		
	b.	<i>dehydration / malnutrition</i>	<i>2 mos</i>																		
	c.	<i>alcoholic disease</i>	<i>10 yrs</i>																		
	d.																				
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown																					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No																					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred													
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)																	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																					
29b. Signature and title of certifier <i>Dr. [Signature]</i>				29c. License number <i>D29769</i>		29d. Date signed (Month, Day, Year) <i>8/28/00</i>															
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Margeline D. Blumwiese MD 516 N. Rolling Rd Baltimore, Md.</i>																					
31. Date filed (Month, Day, Year) <i>UG 3 1 2000</i>				32. Registrar's Signature <i>[Signature]</i>																	

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27592

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JOHN ALEXANDER</b>				2. Date of Death Month Day Year <b>AUGUST 17 2000</b>		3. Time of Death <b>11:50 AM</b>		
	4a. Facility Name (If not Institution, give street and number) <b>Southern Maryland Hospital Center</b>				4b. City, Town, or Location of Death <b>Clinton</b>		4c. County of Death <b>Prince George's</b>		
Funeral Director	5. Social Security Number <b>053-01-6162</b>		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (in yrs. last birthday) <b>93</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Dec. 13, 1906</b>		
	9. Birthplace (State or Foreign Country) <b>Scotland</b>		10a. State <b>Maryland</b>		10b. County <b>Charles</b>		10c. City, Town or Location <b>Bryans Road</b>		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>6734 Amherst Road</b>		10f. Zip Code <b>20616</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Bookkeeper</b>		16b. Kind of Business/Industry <b>Wholesale Grocery</b>		17. Father's Name (First, Middle, Last) <b>John Alexander</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Margaret Leslie McGregor</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Margaret A. Beigel/Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6734 Amherst Road, Bryans Road, Maryland 20616</b>					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Huntt Crematory</b>		20c. Date <b>08-18-2000</b>		20d. Location - City or Town, State <b>Waldorf, Maryland</b>			
21. Signature of Funeral Service Licensee <b>MARK G. BROHAWN MO0053</b>		22. Name and Address of Facility <b>The Hunt Funeral Home, Inc. P. O. Box 156, Waldorf, Maryland 20604</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>Respiratory Failure</b> Due to (or as a consequence of): <b>Bilateral pneumonia</b> Due to (or as a consequence of): <b>Probable malignancy</b> Due to (or as a consequence of): <b>Anemia</b>		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		Approximate Interval Between Onset and Death	
23c. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Dysphagia</b> <b>Malnutrition</b>				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) <b>M</b>		28b. Time of Injury <b>M</b>	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Dr. Rosario Fernandez</b>		29c. License number <b>D19518</b>		29d. Date signed (Month, Day, Year) <b>8/17/00</b>			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>F. Rosario Fernandez</b> <b>7700 Old Branch Ave. C102 Clinton, Maryland 20735</b>		31. Date filed (Month, Day, Year) <b>AUG 21 2000</b>		32. Registrar's Signature <b>B. Sparks</b>					

1993-10-10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27593

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Doris Jeanette May Ard				2. Date of Death Month Day Year August 19, 2000		3. Time of Death 1315			
	4a. Facility Name (If not institution, give street and number) Harford Memorial Hospital				4b. City, Town, or Location of Death Havre de Grace		4c. County of Death Harford			
Funeral Director	5. Social Security Number 255-46-0954		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 67 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 7, 1932		9. Birthplace (State or Foreign Country) Georgia	
	Usual Residence of Decedent									
10a. State Maryland		10b. County Cecil		10c. City, Town or Location Perryville				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 615 Aiken Avenue				10f. Zip Code 21903		10g. Citizen of What Country? U.S.A.				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Twelve Years College (14 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Emergency Room Registrar			16b. Kind of Business/Industry Harford Memorial Hospital Havre de Grace, Maryland			
17. Father's Name (First, Middle, Last) Walter S. May					18. Mother's Name (First, Middle, Maiden Surname) Arline Jeanette Hinley					
19a. Informant's Name/Relationship (Type, Print) William R. Ard (Husband)					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 615 Aiken Avenue, Perryville, Maryland 21903					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) New Bridge Baptist Church Cemetery		Date 8/22/00		20c. Location - City or Town, State Rising Sun, Maryland			
21. Signature of Funeral Service Licensee Thomas M. Patterson, Sr.					22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Anoxic encephalopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Approximate Interval Between Onset and Death few days										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier Claudia A. Krober MD, FACP					29c. License number D50040		29d. Date signed (Month, Day, Year) 08.20.2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Claudia A. Krober 1308 Business Center Way Havre de Grace MD										
31. Date filed (Month, Day, Year) AUG 22 2000					32. Registrar's Signature Bernita B. Sparks					

ORIGINAL

1101

1102

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State of Maryland / Department of Health and Mental Hygiene 00 27594

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ROBERT H. ALEXANDER				2. Date of Death Month Day Year AUGUST 16, 2000		3. Time of Death 5:25am	
	4a. Facility Name (If not institution, give street and number) 3847 ST. BARNABAS RD # 104				4b. City, Town, or Location of Death SUITLAND		4c. County of Death PRINCE GEORGES	
Funeral Director	5. Social Security Number 577-32-6508		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 73 Yrs.		8. Date of Birth (Month, Day, Year) SEPT 24, 1927	
	9. Birthplace (State or Foreign Country) WASHINGTON DC		10a. State MD		10b. County PRINCE GEORGES		10c. City, Town or Location SUITLAND	
Usual Residence of Decedent								
10a. State MD			10b. County PRINCE GEORGES			10c. City, Town or Location SUITLAND		
10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			10e. Street and Number 3847 ST. BARNABAS RD #104			10f. Zip Code 20746		
10g. Citizen of What Country? UNITED STATES			11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: BLACK			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SUPERVISOR			16b. Kind of Business/Industry U.S. GOVT			17. Father's Name (First, Middle, Last) GEORGE ALEXANDER		
18. Mother's Name (First, Middle, Maiden Surname) PAULINE ALLEN			19a. Informant's Name/Relationship (Type, Print) ROBIN ALEXANDER / DAUGHTER			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2744 ALBERMARLE PLACE, WALDORF, MD 20601		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) RESURRECTION CEMETERY			20c. Location - City or Town, State 8-22-00 CLINTON, MD		
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility ALEXANDER S. POPE FUNERAL 5538 MARLBORO PIKE, FORESTVILLE, MD 20747			23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. CANCER OF THE ESOPHAGUS Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		
28a. Date of Injury (Month, Day Year)			28b. Time of Injury M			28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier 			29c. License number D24052		
29d. Date signed (Month, Day, Year) AUGUST 17, 2000			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHN MCKNIGHT M.D. 106 IRVING ST N.W. #2200 WASHINGTON DC			31. Date filed (Month, Day, Year) AUG 17 2000		
32. Registrar's Signature 								

ORIGINAL



G 2-4



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27595  
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) FLOYD LIONEL ANDREWS				2. Date of Death Month Day Year August 16, 2000		3. Time of Death 9:46am				
	4e. Facility Name (If not institution, give street and number) NORTH ARUNDEL HOSPITAL				4b. City, Town, or Location of Death GLEN BURNIE		4c. County of Death AAROUNTY				
Funeral Director	5. Social Security Number 243-10-3092		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		8. Date of Birth (Month, Day, Year) 02/28/1917		9. Birthplace (State or Foreign Country) NORTH CAROLINA		
	Usual Residence of Decedent										
10a. State MD			10b. County ANNE ARUNDEL			10c. City, Town or Location CROFTON			10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10a. Street and Number 2131 DAVIDSONVILLE ROAD					10f. Zip Code 21114			10g. Citizen of What Country? U.S.A.			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1944			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+)					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MASTER CARPENTER			16b. Kind of Business/Industry CONSTRUCTION			
17. Father's Name (First, Middle, Last) BARNEY L. ANDREWS					18. Mother's Name (First, Middle, Maiden Surname) LENA ESTELLE BELL						
19a. Informant's Name/Relationship (Type, Print) LENA A. KATZEN/DAUGHTER					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11018 CHANDLER ROAD POTOMAC, MD. 20854						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)					20b. Place of Disposition (Name of cemetery, crematory or other place) LAKEMONT CEMETERY			20c. Location - City or Town, State DAVIDSONVILLE, MD.			
21. Signature of Funeral Service Licensee KYLE SIMONS M01206					22. Name and Address of Facility BEALL FUNERAL HOME 6512 NW CRAIN HWY. BOWIE, MD. 20715						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Chronic obstructive Pulmonary disease 10 years Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier M D					29c. License number D 38958			29d. Date signed (Month, Day, Year) 8/17/2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Daleet Singh Sachin 1413 Annapolis Rd #106 Odenton MD 21113											
31. Date filed (Month, Day, Year) AUG 17 2000					32. Registrar's Signature B. Smith						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

ORIGINAL

August 1960

John Doe

North American

Aug 1 1960

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27596

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

IRIS L AUSTIN

2. Date of Death  
Month Day Year  
AUGUST 12, 20003. Time of Death  
3:53am

4a. Facility Name (If not institution, give street and number)

MARINER OF SOUTHERN MARYLAND

4b. City, Town, or Location of Death

CLINTON

4c. County of Death

PRINCE GEORGES

Funeral  
Director

5. Social Security Number

122-22-9355

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
JULY 26, 1924

9. Birthplace (State or Foreign Country)

EASTMAN, GA

Usual Residence of Decedent

10a. State

MD

10b. County

PRINCE GEORGES

10c. City, Town or Location

SUITLAND

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2424 FAIRHILL DR

10f. Zip Code

20746

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

HOUSEWIFE

16b. Kind of Business/Industry

PRIVATE

17. Father's Name (First, Middle, Last)

JOHN C. BRAY

18. Mother's Name (First, Middle, Maiden Surname)

ROSA LONG

19a. Informant's Name/Relationship (Type, Print)

JOHN AUSTIN / HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2424 FAIRHILL DR., SUITLAND, MD 20746

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HARMONY MEMORIAL PARK

Date

8-19-00

20c. Location - City or Town, State

LANDOVER, MD

21. Signature of Funeral Service Licensee

Keith Savage

22. Name and Address of Facility

ALEXANDER S. POPE FUNERAL HOME

5538 MARLBORO PIKE, FORESTVILLE, MD 20747

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Asystole

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Unknown

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Chronic Renal Failure

Due to (or as a consequence of):

Unknown

c. Diabetes

Due to (or as a consequence of):

Unknown

d. Hypertension

Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Yazdani

29c. License number

56454

29d. Date signed (Month, Day, Year)

August 13, 2000

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

DR. YAZDANI M.D. 1328 SOUTHERN AVE S.E. WASHINGTON DC 20032

31. Date filed (Month, Day, Year)

AUG 16 2000

32. Registrar's Signature

B. Smith

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

6 0/0

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27597

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

NNECHETA EVA ANOCHIE

2. Date of Death

Month Day Year  
AUGUST 7, 2000

3. Time of Death

10:50pm

4a. Facility Name (If not institution, give street and number)

HOLY CROSS HOSPITAL

4b. City, Town, or Location of Death

SILVER SPRING

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

212-04-3887

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

32 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
JAN 24, 1968

9. Birthplace (State or Foreign Country)

WASHINGTON DC

Usual Residence of Decedent

10a. State

MD

10b. County

PRINCE GEORGES

10c. City, Town or Location

GREENBELT

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

7326 MANDAN RD

10f. Zip Code

20770

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

DISABLED

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

ONONEZE MARTIN ANOCHIE

18. Mother's Name (First, Middle, Maiden Surname)

TRONETTE THOMAS

19a. Informant's Name/Relationship (Type, Print)

TRONETTE ANOCHIE / MOTHER

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)

7326 MANDAN RD GREENBELT, MD 20770

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HARMONY MEMORIAL PARK

Date

8-15-00

20c. Location - City or Town, State

LANDOVER, MD

21. Signature of Funeral Service Licensee

Keith Savage

22. Name and Address of Facility ALEXANDER S. POPE FUNERAL HOME

11315 LOCKWOOD DRIVE, SILVERSPRING, MD 20904

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. PULMONRY HYPERTENSION

Due to (or as a consequence of):

b. SICKLE CELL ANEMIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SEIZURE DISORDER

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Linda M. Burrell M.D.

29c. License number

D35996

29d. Date signed (Month, Day, Year)

AUGUST 8, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LINDA BURRELL M.D. 2770 UNIVERSITY BLVD. #400 SILVER SPRING, MD

State  
Registrar

31. Date filed (Month, Day, Year)

AUG 16 2000

32. Registrar's Signature

Linda M. Burrell

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27598

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>BETTY MARIE ANDERSON</b>				2. Date of Death Month <b>August</b> Day <b>17</b> Year <b>2000</b>		3. Time of Death <b>5:15 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>WILLIAMSPORT RETIREMENT VILLAGE</b>				4b. City, Town, or Location of Death <b>WILLIAMSPORT</b>		4c. County of Death <b>WASHINGTON</b>	
Funeral Director	5. Social Security Number <b>358-14-3133</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>95</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>April 26, 1905</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Md.</b>		10b. County <b>Washington</b>		10c. City, Town or Location <b>Hagerstown</b>	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>20119 Trovinger Mill Rd.</b>		10f. Zip Code <b>21742</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+) <b></b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Clerk</b>		16b. Kind of Business/Industry <b>Store</b>			
	17. Father's Name (First, Middle, Last) <b>Joseph Cleveland Longnecker</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Laura Pound</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Betty J. Miner (Niece)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10923 Bower Ave. Hagerstown, Md. 21740</b>			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Smithsburg Crematory</b>		20c. Date <b>Aug. 19, 2000</b>		20d. Location - City or Town, State <b>Smithsburg, Md.</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Md. 21783</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <b>HYPOGLYCEMIA</b> Due to (or as a consequence of): b. <b>DIABETES MELLITUS</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Approximate Interval Between Onset and Death <b>HOURS</b> <b>MONTHS</b>							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>SENILE DEMENTIA; AUTOIMMUNE DISEASE OF UNDETERMINED ETIOLOGY</b>							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier  <b>STAFF PHYSICIAN</b>		29c. License number <b>D42046</b>		29d. Date signed (Month, Day, Year) <b>August 18, 2000</b>	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>GRACE BROOKE HUFFMAN MD 18100 SLADE SCHOOL ROAD SANDY SPRING, MARYLAND 20860</b>							
State Registrar	31. Date filed (Month, Day, Year) <b>AUG 22 2000</b>		32. Registrar's Signature 					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27599

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Esther Oluwasefunmi Apaidu				2. Date of Death Month Day Year August 11 2000		3. Time of Death 07:28 A.M.	
	4a. Facility Name (If not institution, give street and number) Johns Hopkins Bayview				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 579-23-9403	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 32 Yrs.	8. Date of Birth (Month, Day, Year) Dec. 7, 1967	9. Birthplace (State or Foreign Country) Iju, Nigeria			
	Usual Residence of Decedent							
10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring		10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 3010 Hewitt Avenue #275				10f. Zip Code 20906		10g. Citizen of What Country? Nigeria		
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DD NDT use retired) Nurse		16b. Kind of Business/Industry Private Firm		
17. Father's Name (First, Middle, Last) Emmanuel Apaidu				18. Mother's Name (First, Middle, Maiden Surname) Beatrice (last name unavailable)				
19a. Informant's Name/Relationship (Type, Print) Joseph Adefolalu Uncle				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 218-E Falls Street, Morganton, NC 28655				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Glenwood Cemetery		20c. Location - City or Town, State 8/18/00 Washington, D.C.		
21. Signature of Funeral Service Licensee <i>Lynne McGuire</i>				22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Ave. N.W., Washington, D.C. 20012				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <i>Multiple Injuries</i> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) 8-11-00		28b. Time of Injury 6:27 A.M.		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
		28d. Describe how injury occurred <i>motor vehicle collision</i>		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <i>street/tunnel</i>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <i>Ft McHenry Tunnel Baltimore, Md</i>		
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>Dennis Chute, MD</i>				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) August 11, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Dennis Chute, MD</i> 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) AUG 15 2000				32. Registrar's Signature <i>B. Sparks</i>				

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27600

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Joseph Kevin Anderson

2. Date of Death

August 10 2000

3. Time of Death

12:14

4a. Facility Name (If not institution, give street and number)

Stella Maris - Mercy

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

216-74-1204

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

38 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

February 27, 1962

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1611 Freedom Way North

10f. Zip Code

21213

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Home Improvement

16b. Kind of Business/Industry

Grade Company

17. Father's Name (First, Middle, Last)

Albert Anderson, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Blanche Marie Hargrove

19a. Informant's Name/Relationship (Type, Print)

Blanche Anderson / mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1611 Freedom Way North Baltimore, MD 21213

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Chesapeake Crematory, Inc.

Date

8-12-00

20c. Location - City or Town, State

Beltsville, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

CAFA Stephen D. Lohrmann, P.A.

8717 Green Pastures Dr., Towson, MD 21286

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acquired Immodeficiency Syndrome  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence6 ☒ Other (Specify)

hospital

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D40854

29d. Date signed (Month, Day, Year)

8/10/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David Rosenberg 301 St Paul Pl Baltimore 21202

State  
Registrar

31. Date filed (Month, Day, Year)

AUG 16 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

August 12 1904



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27601  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

PEARL ANTONELLI

2. Date of Death

8 - 17 - 2000

3. Time of Death

5 AM

4a. Facility Name (If not institution, give street and number)

Hebrew Home

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

577-56-0910

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 5, 1910

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Kensington

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11304 Newport Mill Road

10f. Zip Code

20895

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation

(Give kind of work done during most of working  
life. DO NOT use retired)

Salesperson

16b. Kind of Business/Industry

Retail sales

17. Father's Name (First, Middle, Last)

Morris

Gach

18. Mother's Name (First, Middle, Maiden Surname)

Katie

Cash

19a. Informant's Name/Relationship (Type, Print)

Nick Antonelli (husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

same as #10

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Judean Gardens

Date

8/18/2000

20c. Location - City or Town, State

Olney, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Donald V. Borgwardt Funeral Home, P.A.  
4400 Powder Mill Road Beltsville, Maryland 2070523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Pneumonia  
Due to (or as a consequence of):Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Anoxic Encephalopathy

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D24942

29d. Date signed (Month, Day, Year)

08/17/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GREGORY A. COMPTON, MD 6121 Montrose Rd Rockville MD

State  
Registrar

31. Date filed (Month, Day, Year)

AUG 18 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

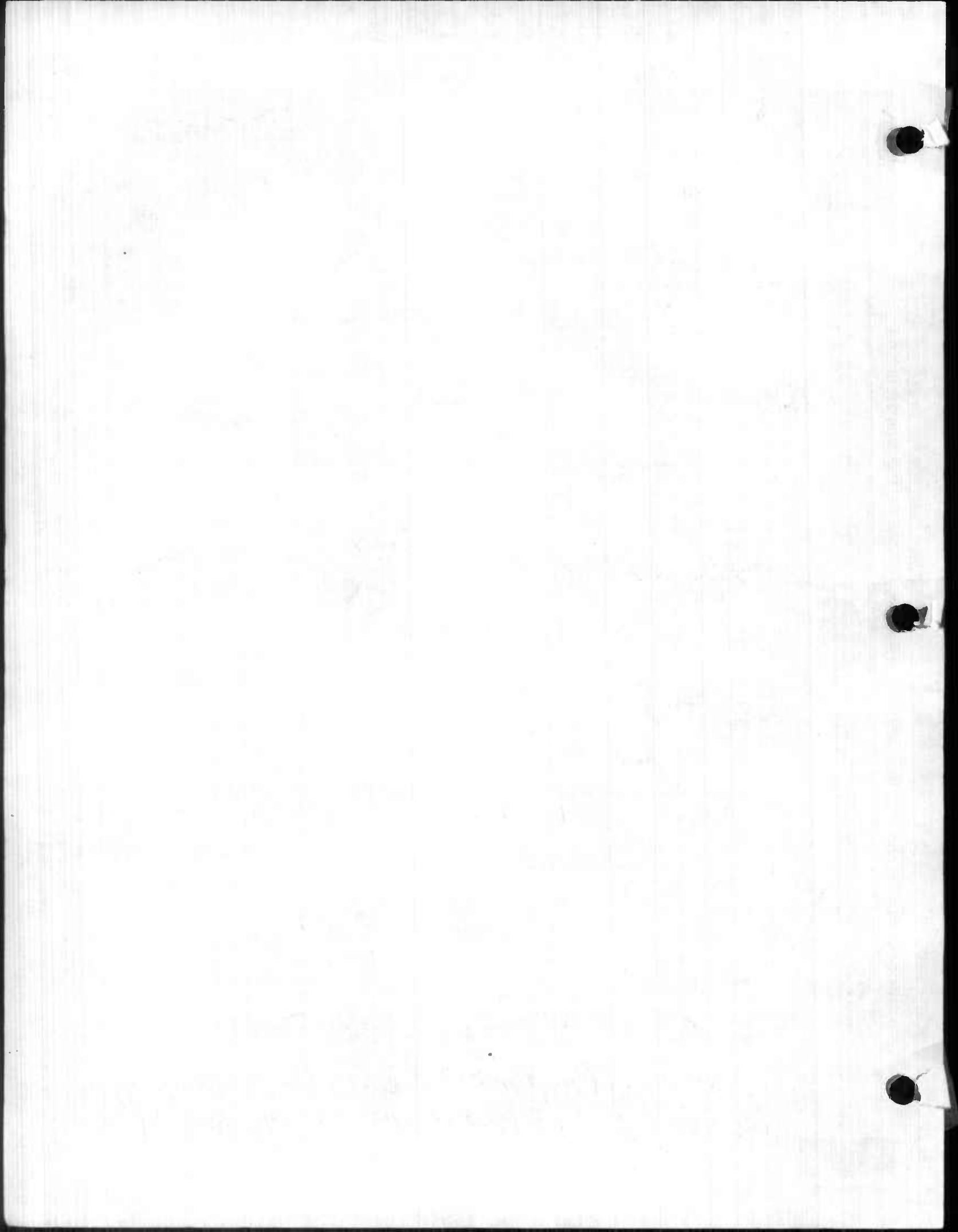
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27602

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DOROTHY

BENDER

2. Date of Death

Month  
AUGUSTDay  
15Year  
2000

3. Time of Death

8:20 AM

4a. Facility Name (If not institution, give street and number)

St. Mary's Hospital

4b. City, Town, or Location of Death

Leonardtwn

4c. County of Death

St. Mary's

Funeral  
Director

5. Social Security Number

218-28-6830

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

66

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
April 8, 1934

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

St. Mary's

10c. City, Town or Location

Lexington Park

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

21463 Esquire Court

10f. Zip Code

20653

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Henry H. Dehn

18. Mother's Name (First, Middle, Maiden Summa)

Julia Preborsiky

19a. Informant's Name/Relationship (Type, Print)

John Allen/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5211 Creek Lane, King George, Virginia 22485

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Ft. Lincoln Cemetery

Date

08-18-2000

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

MARK G. BROHAWN

MO0053

22. Name and Address of Facility

The Hunt Funeral Home, Inc.  
P. O. Box 156, Waldorf, Maryland 20604

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a.

Renal failure

Due to (or as a consequence of):

Months

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b.

Congestive Heart Failure

Due to (or as a consequence of):

Months

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending  
Investigation6 ☐ Could not be  
determined

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29e. Certifier  
(Check only  
one)29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

JAMES BOYD M.D.

29c. License number

014285

29d. Date signed (Month, Day, Year)

8-15-00

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

JAMES BOYD M.D. 23415 THREE NOTCH ROAD CALIFORNIA, MD. 20619

State  
Registrar

31. Date filed (Month, Day, Year)

AUG 21 2000

32. Registrar's Signature

James B. Sparks

Baltimore, Maryland 21215-0020  
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

DOROTHY BENDER

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27603

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Callie Mae Ham Jones Brewer

2. Date of Death

August 21 2000

3. Time of Death

9:45 am

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

1413 Conowingo Road

4b. City, Town, or Location of Death

Rising Sun

4c. County of Death

Cecil

5. Social Security Number

215-32-4026

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Aug. 12, 1919

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State  
Maryland

10b. County

Cecil

10c. City, Town or Location

Rising Sun

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1413 Conowingo Road

10f. Zip Code

21911

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

American Indian

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

David Ham

18. Mother's Name (First, Middle, Maiden Surname)

Dema Calhoun

19a. Informant's Name/Relationship (Type, Print)

Carol Halsey/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1413 Conowingo Road, Rising Sun, MD 21911

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Brown Cemetery

Date

8-26-00

20c. Location - City or Town, State

West Jefferson, NC

21. Signature of Funeral Service Licensee

*Richard L. Gordie*

22. Name and Address of Facility

R. T. Foard Funeral Home, P. A.  
111 S. Queen St., Rising Sun, MD 21911

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):  
*ALZHEIMERS*

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*HYPOHYPOBISM-*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

*7 Biondo 317 S. Queen, Hgt 6, Md, 21078*

31. Date filed (Month, Day, Year)

AUG 22 2000

32. Registrar's Signature

*B. Sparks*State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

00 27604

Amend #20b.Per Phys.PGC 8-25-2000 cr

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Sixtus L. Bernatowicz

2. Date of Death

Month Aug 15 Day 2000 Year

3. Time of Death

5:45 AM

4a. Facility Name (If not institution, give street and number)

Magnolia Gardens Nursing Home

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince Georges

Funeral  
Director

5. Social Security Number

232-44- 6576

6. Sex

M 20 F

7. Age (In yrs. last birthday)

82

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month March Day 28 Year 1918

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Prince Georges

10c. City, Town or Location

New Carrollton

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

8303 Stanwood St.

10f. Zip Code

20784

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 Never Married 2 Married

3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 Yes 2 No

If Yes, Give

Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Military

16b. Kind of Business/Industry

U.S. Army

17. Father's Name (First, Middle, Last)

Frank Bernatowicz

18. Mother's Name (First, Middle, Maiden Surname)

Agnes Zeglatis

19a. Informant's Name/Relationship (Type, Print)

Lucille Bernatowicz - wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8303 Stanwood St. New Carrollton, MD 20784

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Arlington Nat'l Cemetery 8/24/00

Date

20c. Location - City or Town, State

Arlington, VA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Rendon/Hale Funeral Home

9013 Annapolis Rd. Lanham, MD 20706

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. CANCER OF LUNG

Due to (or as a consequence of):

b. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

STROKE

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy  
performed?

1 Yes 2 No

24b. Were autopsy findings  
available prior to  
completion of cause  
of death?

1 Yes 2 No

25. Was case referred to medical  
examiner?

1 Yes 2 No

28. Place of Death (Check only one)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

Other:

4 Nursing Home 5 Residence 8 Other (Specify)

27. Manner of Death

1 Natural 5 Pending investigation

2 Accident

3 Suicide

4 Homicide

8 Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D0050951

29d. Date signed (Month, Day, Year)

8/15/00

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

6510 KENILWORTH AVE RIVERDALE MD 20737

State  
Registrar

31. Date filed (Month, Day, Year)

AUG 18 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23e or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at office.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27605

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Robert Brown				2. Date of Death Month Day Year August 01 2000				3. Time of Death 12:29 P.M.						
	4a. Facility Name (If not institution, give street and number) 5200 block of Silver Hill Road				4b. City, Town, or Location of Death Suitland				4c. County of Death Prince George's						
Funeral Director	5. Social Security Number 425-68-1080		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 65 Yrs.		8. Date of Birth (Month, Day, Year) July 27, 1935		9. Birthplace (State or Foreign Country) Angular, Ms.						
	Usual Residence of Decedent														
10a. State Maryland			10b. County Prince George's			10c. City, Town or Location Forestville			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No						
10e. Street and Number 5062 Silver Hill Ct. Apt. 204						10f. Zip Code 20747		10g. Citizen of What Country? United States							
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black						
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4 or 5+)						16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Construction			16b. Kind of Business/Industry Private						
17. Father's Name (First, Middle, Last) UNKNOWN						18. Mother's Name (First, Middle, Maiden Surname) Lillie Bell Collins									
19a. Informant's Name/Relationship (Type, Print) Robert Lee Brown/ Son						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6702 Westforest Rd. Landover, Md. 20785									
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Memorial Park		20c. Date 8/12/00		20d. Location - City or Town, State Landover, Md.							
21. Signature of Funeral Service Licensee Keith A. Long						22. Name and Address of Facility Alexanders. Pope Funeral Homes 5538 Marlboro Pike/Forestville, Md. 20747									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. EXSANGUINATION Due to (or as a consequence of): b. RIGHT LOWER EXTREMITY INJURIES Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death					
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Scene											
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year) 8/1/00		28b. Time of Injury 1226 PM		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred PEDESTRIAN STRUCK BY METRO BUS					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) STREET						28f. Location (Street and Number or Rural Route Number, City or Town, State) 5200 BLOCK SILVER HILL RD, SUITLAND, MD									
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										29b. Signature and title of certifier J. H. C. M.D.		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) August 2, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARY G. RIPLEY, M.D. 111 Penn Street, Baltimore, Maryland 21201															
31. Date filed (Month, Day, Year) AUG 18 2000				32. Registrar's Signature Benita G. Smith											

Baltimore, Maryland 21215-0020  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director  
To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27606

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Ruth Vivian Benton</b>		2. Date of Death Month Day Year <b>Aug. 15 2000</b>		3. Time of Death <b>12:35 P</b>
	4a. Facility Name (If not institution, give street and number) <b>2800 Chapman Court</b>		4b. City, Town, or Location of Death <b>Crofton</b>		4c. County of Death <b>Anne Arundel</b>
Funeral Director	5. Social Security Number <b>147-18-3294</b>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>75</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>July 29, 1925</b>	9. Birthplace (State or Foreign Country) <b>New Jersey</b>
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State <b>Md.</b>	10b. County <b>Anne Arundel</b>	10c. City, Town or Location <b>Crofton</b>		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
	10e. Street and Number <b>2800 Chapman Court</b>		10f. Zip Code <b>21114</b>		10g. Citizen of What Country? <b>USA</b>
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Fred Zeeb</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Marie Madsen</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Patrick J. Benton/Nephew</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2800 Chapman Court, Crofton, Md. 21114</b>		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Calverton Nat'l Cem.</b>		
	21. Signature of Funeral Service Licensee <b>Robert G. Beall/M00025</b>		22. Name and Address of Facility <b>6512 N.W. Crain Hwy., Bowie, Md. 20715</b>		
	23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. CARDIOPULMONARY ARREST</b> Due to (or as a consequence of): <b>b. SEVERE CARDIOMYOPATHY</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>c.</b> Due to (or as a consequence of): <b>d.</b>		Approximate Interval Between Onset and Death		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CONGESTIVE HEART FAILURE</b> <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b>					
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	28b. Time of Injury <b>M</b>	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>[Signature]</b>		29c. License number <b>D43230</b>	29d. Date signed (Month, Day, Year) <b>8/16/00</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DAVID ANDERSON 2448 Holly Ave Suite 100, Annapolis, Md. 21401</b>					
31. Date filed (Month, Day, Year) <b>AUG 17 2000</b>		32. Registrar's Signature <b>[Signature]</b>			

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27607

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Paul Jennings Barber				2. Date of Death Month Day Year August 11, 2000				3. Time of Death 5:05 pm					
	4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital				4b. City, Town, or Location of Death Clinton				4c. County of Death Prince George's					
Funeral Director	5. Social Security Number 577-05-5747		6. Sex M <input checked="" type="checkbox"/> F <input type="checkbox"/>		7. Age (In yrs. last birthday) 89 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) Sept. 17, 1910		9. Birthplace (State or Foreign Country) Washington, DC	
	Usual Residence of Decedent													
10a. State Maryland				10b. County Prince George's				10c. City, Town or Location Greenbelt				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 69-K Ridge Road						10f. Zip Code 20770				10g. Citizen of What Country? U.S.A.				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (1-4 or 5+) -						16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Baker				16b. Kind of Business/Industry Giant Inc.				
17. Father's Name (First, Middle, Last) William C. Barber						18. Mother's Name (First, Middle, Maiden Surname) Margaret Jennings								
19a. Informant's Name/Relationship (Type, Print) Bill Barber - Son						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 65-C Ridge Road, Greenbelt, MD 20770								
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)						20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemetery				20c. Location - City or Town, State 8/15/00 Brentwood, MD				
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <u>Acute Respiratory Failure</u> Due to (or as a consequence of): <u>unknown</u> b. <u>Congestive heart Failure</u> Due to (or as a consequence of): <u>unknown</u> c. <u>Chemia</u> Due to (or as a consequence of): <u>unknown</u> d.														
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				
										24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred				
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.														
29b. Signature and title of certifier 						29c. License number 50454				29d. Date signed (Month, Day, Year) August 12, 2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Arastoo Yazdani 7503 Surratts Road, Clinton, MD 20735														
31. Date filed (Month, Day, Year) AUG 14 2000				32. Registrar's Signature 										

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27608

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Walter Joseph Bonfield

2. Date of Death

Month Day Year  
August 9, 2000

3. Time of Death

4:10 AM

4a. Facility Name (If not institution, give street and number)

Crofton Nursing Center

4b. City, Town, or Location of Death

Crofton

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

500-22-5379

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

87

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Apr. 12, 1913

9. Birthplace (State or Foreign Country)

England

Usual Residence of Decedent

10a. State

Md.

10b. County

Anne Arundel

10c. City, Town or Location

Crofton

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1558 Farlow Avenue

10f. Zip Code

21114

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Mechanic

16b. Kind of Business/Industry

Self employed

17. Father's Name (First, Middle, Last)

Charles Bonfield

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Peale

19a. Informant's Name/Relationship (Type, Print)

Helen Bonfield Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1558 Farlow Ave., Crofton, Md. 21114

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

National Mem. Park 08-16-00 Falls Church, VA.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Robert G. Beall

M00025

22. Name and Address of Facility

Beall Funeral Home

6512 N.W. Crain Hwy., Bowie, Md. 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Aspiratia pneumonia  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

1 week

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Advanced dementia

Depression

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Paul S. Rhodes, M.D.

29c. License number

D22028

29d. Date signed (Month, Day, Year)

8-9-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paul S. Rhodes, M.D.

1667 Crofton Ctr Crofton, MD 21114

State  
Registrar

31. Date filed (Month, Day, Year)

AUG 14 2000

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27609

amend item 23a,pt,II,27 per me G787 9/26/00 yf

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Tatia R. Bullock</b>				2. Date of Death Month Day Year <b>August 18 2000</b>				3. Time of Death <b>09:12 A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Prince George's Hospital Center</b>				4b. City, Town, or Location of Death <b>Cheverly</b>				4c. County of Death <b>Prince George's</b>	
Funeral Director	5. Social Security Number <b>215-84-5333</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>27</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Jan. 3, 1973</b>		9. Birthplace (State or Foreign Country) <b>Washington, DC</b>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>Prince Georges</b>		10c. City, Town or Location <b>New Carrollton</b>				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number <b>6425 Fairborn Terrace</b>				10f. Zip Code <b>20784</b>		10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>2yrs</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Customer Consultant</b>				16b. Kind of Business/Industry <b>Verizon</b>			
	17. Father's Name (First, Middle, Last) <b>Jerome Bullock</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Irma Davis</b>					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Irma Bullock/Mother</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6425 Fairborn Terrace New Carrollton, MD 20784</b>					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Ft. Lincoln Cemetery</b>		Date <b>8-25-00</b>		20c. Location - City or Town, State <b>Brentwood, MD.</b>			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Marshall's Funeral Home, Inc. 4217 9th St. N.W. Washington, D.C. 20011</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>SEIZURE DISORDER</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>MORBID OBESITY</b> Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):									
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
Medical Certification: To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No									
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No									
	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No									
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)										
28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 				29c. License number <b>O.C.M.E.</b>				29d. Date signed (Month, Day, Year) <b>August 19, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>J. P. Marshall 111 Penn Street, Baltimore, Maryland 21201</b>										
State Registrar	31. Date filed (Month, Day, Year) <b>AUG 23 2000</b>				32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23c show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27610

Amend Item 7, 8/22/00, Cecil Co., bath

Reg. No.

## Certificate of Death

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Ann F. Czerwinski</b>				2. Date of Death Month <b>August</b> Day <b>16</b> Year <b>2000</b>				3. Time of Death <b>0200</b>		
	4e. Facility Name (If not institution, give street and number) <b>Sun Bridge Care Center</b>				4b. City, Town, or Location of Death <b>Elkton</b>				4c. County of Death <b>Cecil</b>		
Funeral Director	5. Social Security Number <b>222-14-9947</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>68</b> Yrs.		8. Date of Birth Month <b>January</b> Day <b>29</b> Year <b>1914</b>		9. Birthplace (State or Foreign Country) <b>Pa.</b>		
	Usual Residence of Decedent										
10a. State <b>De.</b>		10b. County <b>New Castle</b>		10c. City, Town or Location <b>Wilmington</b>				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
10e. Street and Number <b>1604 Stoney Run Drive</b>				10f. Zip Code <b>19803</b>				10g. Citizen of What Country? <b>USA</b>			
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Sales</b>				16b. Kind of Business/Industry <b>Clothing</b>			
17. Father's Name (First, Middle, Last) <b>Anthony Czerwinski</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Emilia Kaminski</b>							
19a. Informant's Name/Relationship (Type, Print) <b>Howard Smentkowski, Nephew</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>143 Alleghany Rd. Stevensville, Md. 21666</b>							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cathedral Cemetery</b>				20c. Location - City or Town, State <b>Wilm., De.</b>			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>259 E. Main Street, Gee Funeral Home Elkton, Md. 21921</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Dementia of Alzheimer's Type</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>										Approximate Interval Between Onset and Death <b>years</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Coronary Artery Disease</b>								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
				28d. Describe how injury occurred							
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							
				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier 				29c. License number <b>D23322</b>				29d. Date signed (Month, Day, Year) <b>8.16.2000</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>S. S. SACHDEV MD, 118 North St Suite 3B, Elkton MD 21921.</b>											
31. Date filed (Month, Day, Year) <b>AUG 17 2000</b>				32. Registrar's Signature 							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27611

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

John Dennis Coughlin

2. Date of Death

AUGUST 21, 2000

3. Time of Death

1:10 AM

4a. Facility Name (If not institution, give street and number)

VA MARYLAND HEALTHCARE SYSTEM

4b. City, Town, or Location of Death

PERRY POINT

4c. County of Death

CECIL

Funeral  
Director

5. Social Security Number

215-09-1617

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct. 19, 1911

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Bel Air

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

955 Sablewood Road

10f. Zip Code

21014

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

Twelve Years

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Postal Clerk

16b. Kind of Business/Industry

U.S. Postal Service

Lenox, Massachusetts

17. Father's Name (First, Middle, Last)

John J. Coughlin

18. Mother's Name (First, Middle, Maiden Surname)

Helen Doyle

19a. Informant's Name/Relationship (Type, Print)

Jill Sohl

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

511 M Cider Press Court, Joppa, Maryland 21085

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

St. Ann Cemetery

Date

8/24/00

20c. Location - City or Town, State

Lenox, Massachusetts

21. Signature of Funeral Service Licensee

Thomas M. Patterson, Sr.

22. Name and Address of Facility

Lee A. Patterson &amp; Son Funeral Home, P.A.

Perryville, Maryland 21903-0766

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

UNKNOWN

a. Due to (or as a consequence of):

TRANSIENT ISCHEMIC ATTACK

UNKNOWN

b. Due to (or as a consequence of):

SEIZURES

UNKNOWN

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Samir Kheiri

29c. License number

D0052064

29d. Date signed (Month, Day, Year)

AUGUST 21, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAMIR KHEIRI, M.D., VA MARYLAND HEALTHCARE SYSTEM, PERRY POINT, MD 21902

State  
Registrar

31. Date filed (Month, Day, Year)

AUG 22 2000

32. Registrar's Signature

B. Sparks

NAME KNOWN TO PHYSICIAN: COUGHLIN, JOHN D

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: 5 PER F.H. G787 9-22-00 **Certificate of Death**

Reg. No.

00 27612

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>AGNES CARR</b>		2. Date of Death Month <b>X 8</b> Day <b>15</b> Year <b>2009</b>		3. Time of Death <b>1205p</b>
	4a. Facility Name (If not institution, give street and number) <b>Mariner Health of Silver Spring</b>		4b. City, Town, or Location of Death <b>Silver Spring</b>		4c. County of Death <b>MONT</b>
Funeral Director	5. Social Security Number <b>589-26-4763</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>90</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>9/9/09</b>		9. Birthplace (State or Foreign Country) <b>WASHINGTON, DC</b>		
Usual Residence of Decedent					
10a. State <b>MD</b>		10b. County <b>MONT</b>		10c. City, Town or Location <b>ROCKVILLE</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number <b>12917 LARKIN PLACE</b>			10f. Zip Code <b>20853</b>		10g. Citizen of What Country? <b>USA</b>
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7TH GRADE</b>		College (1-4or 5+) <b>NONE</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>DOMESTIC/HOUSEWIFE</b>	
16b. Kind of Business/Industry <b>OWN HOME</b>					
17. Father's Name (First, Middle, Last) <b>SAMUEL WHITE</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>LILLIAN (UNKNOWN)</b>		
19a. Informant's Name/Relationship (Type, Print) <b>ELLIOTT BRUCE CARR (GRANDSON)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2607 SOUTHERN AVENUE #B2, TEMPLE HILLS, MD 20748</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>HARMONY MEM PK CEM</b>		20c. Location - City or Town, State <b>8/21/2000 LANDOVER, MD.</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>JOHN T. RHINES CO., INC. 3030 12TH ST N E, DC 20017</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		e. <b>ALZHEIMER'S DEMENTIA</b>			
		Due to (or as a consequence of):			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. Due to (or as a consequence of):			
		c. Due to (or as a consequence of):			
		d. Due to (or as a consequence of):			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
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27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number <b>D34032</b>		29d. Date signed (Month, Day, Year) <b>8/16/2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JEANNE P ASNER, MD 3720 FARRAGUT AVE., KENSINGTON, MD 20895</b>					
31. Date filed (Month, Day, Year) <b>AUG 18 2000</b>		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

perml. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27613

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Martin Joseph Clune

2. Date of Death

Month Day Year  
August 15, 2000

3. Time of Death

11:00 AM

4a. Facility Name (If not institution, give street and number)

6208 41st Avenue

4b. City, Town, or Location of Death

Hyattsville

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

077-12-0491

6. Sex

15 M 2 F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct. 7, 1914

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

6208 41st Avenue

10f. Zip Code

20782

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 Never Married 2 Married  
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 Yes 2 No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 Yes 2 No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Aeronautical Engineer

16b. Kind of Business/Industry

Vitro Laboratories

17. Father's Name (First, Middle, Last)

Martin Joseph Clune

18. Mother's Name (First, Middle, Maiden Surname)

Annie O'Gorman

19a. Informant's Name/Relationship (Type, Print)

Agatha G. Clune - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6208 41st Avenue, Hyattsville, MD 20782

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State  
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

8/18/00

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Gasch's Funeral Home, P.A.  
Hyattsville, MD 20781

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Alzheimer's Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?  
1 Yes 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

Other:

26. Place of Death (Check only one)

4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide  
5 Pending investigation 6 Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier  
(Check only one)

1 Certifying Physician:

2 Medical Examiner:

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

201852

29d. Date signed (Month, Day, Year)

August 15, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paul A. DEVORE MD 4203 Queensbury Rd Hyattsville MD 20781

State  
Registrar

31. Date filed (Month, Day, Year)

AUG 16 2000

32. Registrar's Signature

B. Smith

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

10



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27614

## Certificate of Death

Reg. No.

Amend# 23a Per ME PGC 8-25-2000 cr

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedant's Name (First, Middle, Last)

WILLIE B. CRUTCHFIELD

2. Date of Death

June 8, 2000 9:34 AM

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Prince George's Community Hospital

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

5. Social Security Number

411-64-5307

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

61 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
April 19, 1939

9. Birthplace (State or Foreign Country)

Tennessee

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George's

10c. City, Town or Location

Capitol Heights

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1126 Quo Avenue

10f. Zip Code

20743

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Correctional Officer

16b. Kind of Business/Industry

D.C. Dept. of Correct.

17. Father's Name (First, Middle, Last)

Milton Crutchfield

18. Mother's Name (First, Middle, Maiden Surname)

Lula Williams

19a. Informant's Name/Relationship (Type, Print)

E'Lois G. Waller - Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1220 Aspen Street N.W. Washington DC 20012

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Forest Hills Cemetery

Date

6-15-2000 Chattanooga, TN

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Julia P. Marshall

22. Name and Address of Facility

Marshall's Funeral Home, Inc.

4217 9th Street N.W. Washington DC 20011

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
stroke, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. CARDIOPULMONARY ARREST

Due to (or as a consequence of):

b. ACUTE MYOCARDIAL INFARCTION

Due to (or as a consequence of):

c. ASYSTOLE

Due to (or as a consequence of):

d. ASYSTOLE

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

H/O HYPERTENSION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner as stated.

29b. Signature and title of certifier

Anil K. Mahajan MD

29c. License number

D50689

29d. Date signed (Month, Day, Year)

06/08/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANIL K. MAHAJAN PGHOSPITAL RD CHEVERLY MD 20745

31. Date filed (Month, Day, Year)

JUN 13 2000

32. Registrar's Signature

B. B. B.

State  
Registrar

Baltimore, Maryland 21215-0020

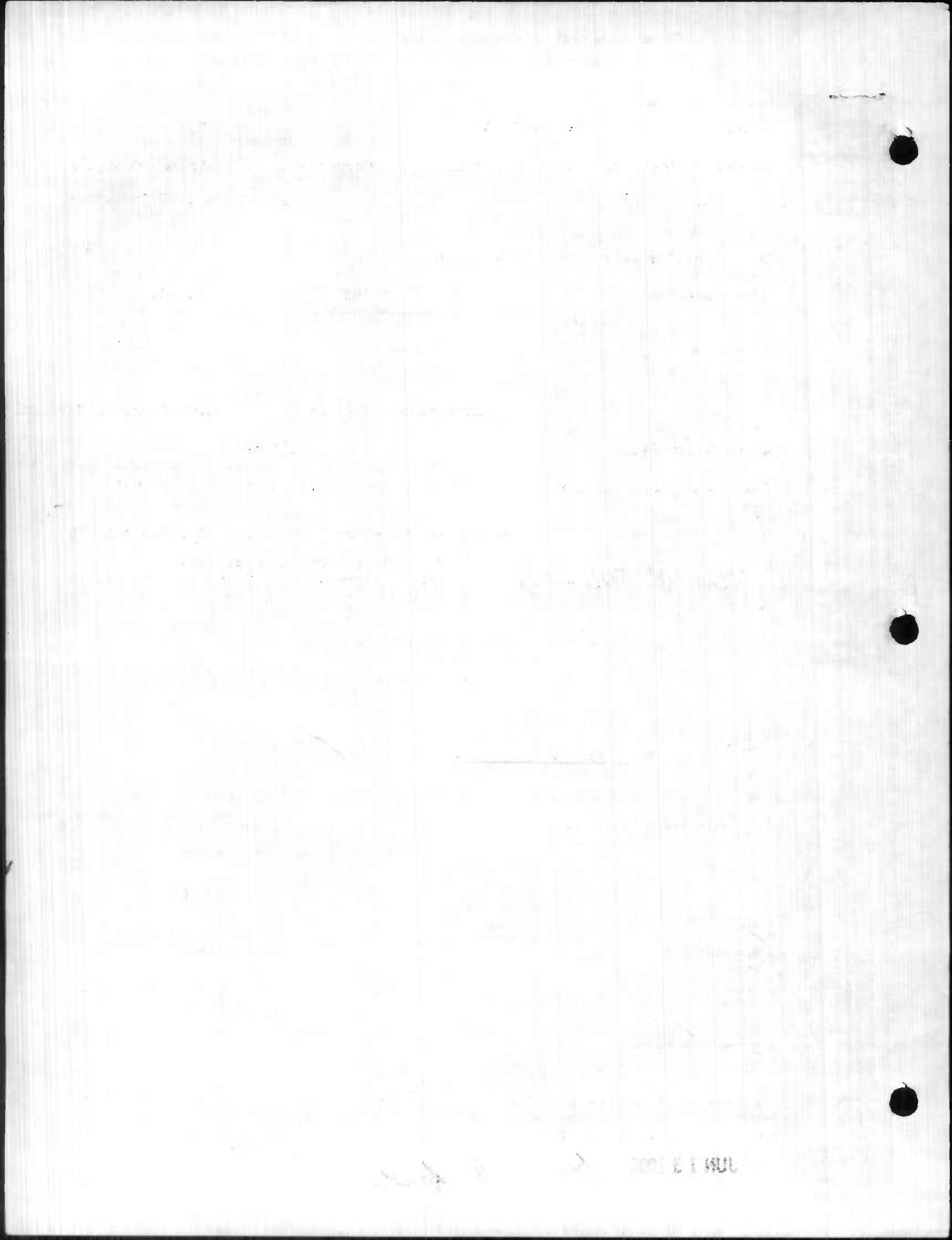
penn. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27615

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Tony Lee Carbaugh

2. Date of Death

Month Day Year  
AUGUST 12, 2000

3. Time of Death

15:15 PM

4a. Facility Name (If not institution, give street and number)

KEMP MILL ROAD

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

WASHINGTON

Funeral  
Director

5. Social Security Number

218-08-1019

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

18

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
May 3, 1982

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

W. Va.

10b. County

Roane

10c. City, Town or Location

Spencer

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

H C 73 Box 41

10f. Zip Code

25276

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

meat cutter

16b. Kind of Business/Industry

grocery store

17. Father's Name (First, Middle, Last)

Harry B. Carbaugh

18. Mother's Name (First, Middle, Maiden Surname)

Peggy Ann McCormick

19a. Informant's Name/Relationship (Type, Print)

Peggy A. Holcomb Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

H C 73 Box 41 Spencer West Virginia 25276

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Smithsburg Crematory

Date

8/17/00

20c. Location - City or Town, State

Smithsburg, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Gerald N. Minnich  
Funeral Home

305 N. Potomac Street

Hagerstown, Maryland 21740

Approximate Interval Between Onset and Death

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Bruise Force Head Injuries  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. \_\_\_\_\_  
Due to (or as a consequence of):c. \_\_\_\_\_  
Due to (or as a consequence of):d. \_\_\_\_\_  
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

SCENE

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☒ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

8/12/00

28b. Time of Injury

12:25 PM

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

SUBJECT STRUCK WITH BLUNT OBJECT

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

UNKNOWN

28f. Location (Street and Number or Rural Route Number, City or Town, State)

UNKNOWN

29a. Certifier (Check only one)

1 ☐ Certifying Physician2 ☒ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

OCME

29d. Date signed (Month, Day, Year)

AUGUST 13, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JACK M. TIMS, M.D.

111 Penn Street, Baltimore, Maryland 21201

State  
Registrar

31. Date filed (Month, Day, Year)

AUG 17 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27616

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary Alice Doss				2. Date of Death Month Day Year August 18, 2000				3. Time of Death 8:30 pm	
	4a. Facility Name (If not institution, give street and number) CITIZENS NURSING HOME				4b. City, Town, or Location of Death HAVRE DE GRACE				4c. County of Death HARFORD	
Funeral Director	5. Social Security Number 216-30-6822		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 90 Yrs.		8. Date of Birth (Month, Day, Year) May 6, 1910		9. Birthplace (State or Foreign Country) Virginia	
	Usual Residence of Decedent									
10a. State Maryland		10b. County Harford		10c. City, Town or Location Havre de Grace				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 415 South Market Street				10f. Zip Code 21078		10g. Citizen of What Country? United States				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4or 5+) 6				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry In her own home			
17. Father's Name (First, Middle, Last) N.E. Moses					18. Mother's Name (First, Middle, Maiden Surname) Etta J. McGraw					
19a. Informant's Name/Relationship (Type, Print) Jane Williams / Daughter					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 66, Charlestown, Maryland 21914					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Charlestown Cemetery		Date August 21, 2000		20c. Location - City or Town, State Charlestown, Maryland			
21. Signature of Funeral Service Licensee [Signature]					22. Name and Address of Facility Crouch Funeral Home, 127 South Main Street, North East, Maryland 21901					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Renal failure Due to (or as a consequence of): b. Dehydration Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 1 wk - 2 wks.										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHF - Malnutrition										
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							
29b. Signature and title of certifier [Signature] MD			29c. License number 032609				29d. Date signed (Month, Day, Year) 8/19/00			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kamran Muhammad 1106 Revolution St Havre de Grace MD 21078										
31. Date filed (Month, Day, Year) AUG 21 2000			32. Registrar's Signature [Signature] B. Sparks							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27617

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Edison Duckett</b>		2. Date of Death Month <b>August</b> Day <b>18</b> Year <b>2000</b>		3. Time of Death <b>10:40 am</b>
	4a. Facility Name (If not institution, give street and number) <b>Southern Maryland Hospital</b>		4b. City, Town, or Location of Death <b>Clinton</b>		4c. County of Death <b>Prince Georges</b>
Funeral Director	5. Social Security Number <b>218-16-3104</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>78</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min
	8. Date of Birth (Month, Day, Year) <b>August 5, 1922</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State <b>Maryland</b>		10b. County <b>Prince Georges</b>
	10c. City, Town or Location <b>Brandywine</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>12809 Heatherwick Ct.</b>		10f. Zip Code <b>20613</b>		10g. Citizen of What Country? <b>U.S.A.</b>
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify <b>Black</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Skilled Labor</b>		16b. Kind of Business/Industry <b>Department of Public Works</b>		
	17. Father's Name (First, Middle, Last) <b>Oscar Duckett</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Victorine M. Duckett</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Mary Rose Duckett/Wife</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12809 Heatherwick Ct. Brandywine Maryland 20613</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Asbury Meth. Ch.</b>		20c. Location - City or Town, State <b>August 24, 2000 Brandywine MD</b>
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>M191 Adams Funeral Home P.A. Aquasco MD 20608</b>		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Acute Myocardial Infarction</b> Due to (or as a consequence of):				Approximate Interval Between Onset and Death
	b. Due to (or as a consequence of):				
	c. Due to (or as a consequence of):				
	d. Due to (or as a consequence of):				
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number <b>D40324</b>		29d. Date signed (Month, Day, Year) <b>August 18, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>TERRY JODRIE, M.D. SOUTHERN MARYLAND HOSPITAL CENTER, CLINTON, MARYLAND</b>					
State Registrar	31. Date filed (Month, Day, Year) <b>AUG 22 2000</b>		32. Registrar's Signature 		

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State of Maryland / Department of Health and Mental Hygiene

00 27618

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Bettie Sue Deans</b>				2. Date of Death Month Day Year <b>Aug. 12 2000</b>		3. Time of Death <b>1:30 P.M.</b>		
	4a. Facility Name (If not institution, give street and number) <b>Manor Care Largo</b>				4b. City, Town, or Location of Death <b>Largo</b>		4c. County of Death <b>P.G.</b>		
Funeral Director	5. Social Security Number <b>243-56-5203</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>93</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>7/21/1907</b>		
	9. Birthplace (State or Foreign Country) <b>N.C.</b>		10a. State <b>MD</b>		10b. County <b>P.G.</b>		10c. City, Town or Location <b>Upper Marlboro</b>		
Usual Residence of Decedent		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number <b>9745 Wyman Way</b>		10f. Zip Code <b>20772</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Domestic</b>		16b. Kind of Business/Industry <b>Private</b>		17. Father's Name (First, Middle, Last) <b>William Taylor</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Susie Newsom</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Susan Jackson</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9745 Wyman Way Upper Marlboro, MD. 20772</b>					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cedar Hill Cemetery</b>		20c. Date <b>8/17/00</b>		20d. Location - City or Town, State <b>Suitland, Md.</b>			
21. Signature of Funeral Service Licensee <b>Spence Edwards</b>				22. Name and Address of Facility <b>Hodges and Edwards 3910 Silver Hill RD. Suitland, MD. 20746</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stroke, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. <b>Atherosclerotic CardioVascular Disease</b> years Due to (or as a consequence of): b. <b>Atherosclerotic CerebroVascular Disease</b> years Due to (or as a consequence of): c. <b>Diabetes Mellitus</b> months Due to (or as a consequence of): d.						Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Rakesh Arora MD</b>		29c. License number <b>D20108</b>		29d. Date signed (Month, Day, Year) <b>8/17/00</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Rakesh Arora MD 143000 Gallant Fox Lane Bowie, MD 20715</b>									
31. Date filed (Month, Day, Year) <b>AUG 18 2000</b>		32. Registrar's Signature <b>B. Spence</b>							

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27619

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>RHOVETTA DOLL</b>				2. Date of Death Month Day Year <b>August 14 2000</b>		3. Time of Death <b>14:58 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Prince George's Hospital Center</b>				4b. City, Town, or Location of Death <b>Cheverly</b>		4c. County of Death <b>Prince George's</b>		
Funeral Director	5. Social Security Number <b>237-02-7897</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>43</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Feb. 26, 1957</b>		
	9. Birthplace (State or Foreign Country) <b>Brooklyn, N.Y.</b>		10a. State <b>Maryland</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Hyattsville</b>		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>2523 Markham Lane</b>		10f. Zip Code <b>20784</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>College (1-4 or 5+)</b> <b>3 Years</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Personnel Management</b>		16b. Kind of Business/Industry <b>Government</b>					
17. Father's Name (First, Middle, Last) <b>Leroy C. Doll</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Dorothy Stewart</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Cherisse Alexander/Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>17704 Kilmarnock Terrace, Germantown, MD 20874</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Harmony Memorial Park</b>		20c. Location - City or Town, State <b>Landover, Maryland</b>		20d. Date <b>8/14/00</b>			
21. Signature of Funeral Service Licensee <b>Nancy A. Perente</b>				22. Name and Address of Facility <b>J.B. JENKINS FUNERAL HOME</b> <b>7474 Landover Road, Landover, Maryland 20785</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>SUBARACHNOID BLEED</b> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____ Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier <b>[Signature]</b>				29c. License number <b>H0054848</b>		29d. Date signed (Month, Day, Year) <b>8/14/00</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Joseph Manna, M.D., 3001 Hospital Drive, Cheverly, Maryland 20785</b>									
31. Date filed (Month, Day, Year) <b>AUG 18 2000</b>		32. Registrar's Signature <b>[Signature]</b>							

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State of Maryland / Department of Health and Mental Hygiene

00 27620

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Richard Lee DEGRANGE</i>				2. Date of Death Month <i>August</i> Day <i>20</i> Year <i>2000</i>				3. Time of Death <i>9:35 AM</i>	
	4a. Facility Name (If not institution, give street and number) <i>Washington County Hospital</i>				4b. City, Town, or Location of Death <i>Hagerstown</i>				4c. County of Death <i>Washington</i>	
Funeral Director	5. Social Security Number <i>215-20-8373</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <i>74</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>July 16 1926</i>		9. Birthplace (State or Foreign Country) <i>Maryland</i>	
	Usual Residence of Decedent				10a. State <i>Maryland</i>		10b. County <i>Washington</i>		10c. City, Town or Location <i>Hagerstown</i>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number <i>19702 Beaver Creek Road</i>				10f. Zip Code <i>21740</i>	
	10g. Citizen of What Country? <i>U.S.A.</i>				11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <i>W.W. II</i>	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <i>White</i>				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4or 5+) <i>1</i>	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Accounting</i>				16b. Kind of Business/Industry <i>Railroad</i>				17. Father's Name (First, Middle, Last) <i>Lawrence C. DeGrange</i>	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) <i>Elizabeth Ann Kogelchatz</i>				19a. Informant's Name/Relationship (Type, Print) <i>Virginia DeGrange - Wife</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>19702 Beaver Creek Road Hagerstown, Md. 21740</i>	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Rest Haven Cemetery</i>				20c. Location - City or Town, State <i>8/23/2000 Hagerstown, Maryland</i>	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>Scott M...</i>				22. Name and Address of Facility <i>Minnich Funeral Home</i> <i>415 E. Wilson Blvd. Hagerstown, Maryland</i>				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <i>Respiratory failure</i> Due to (or as a consequence of): <i>Chronic Obstructive Pulmonary Disease</i> Due to (or as a consequence of): <i>20 years</i> Due to (or as a consequence of): <i>20 years</i> Due to (or as a consequence of): <i>20 years</i>	
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day, Year) <i>28b. Time of Injury M</i>				28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28d. Describe how injury occurred	
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
	29b. Signature and title of certifier <i>Michael J. McCormack MD</i>				29c. License number <i>041607</i>				29d. Date signed (Month, Day, Year) <i>8.21.00</i>	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Michael McCormack 11110 Medical Center Hagerstown, MD 21742</i>				31. Date filed (Month, Day, Year) <i>AUG 22 2000</i>				32. Registrar's Signature <i>Sparks</i>	
	31. Date filed (Month, Day, Year) <i>AUG 22 2000</i>				32. Registrar's Signature <i>Sparks</i>					



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State of Maryland / Department of Health and Mental Hygiene

00 27621

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>NICOLE L. DEWS</b>				2. Date of Death Month <b>August</b> Day <b>13</b> Year <b>2000</b>		3. Time of Death <b>06:28 A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Prince George's Hospital Center</b>				4b. City, Town, or Location of Death <b>Cheverly</b>		4c. County of Death <b>Prince George's</b>	
Funeral Director	5. Social Security Number <b>579-06-7220</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>18</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>December 9, 1981</b>		9. Birthplace (State or Foreign Country) <b>Washington, D.C.</b>
	Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Upper Marlboro</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>3106 Altair Lane</b>				10f. Zip Code <b>20774</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Cashier</b>		16b. Kind of Business/Industry <b>Food Service</b>		
17. Father's Name (First, Middle, Last) <b>Wallace D. Dews</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Sheila Williams</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Hope Dews-Taylor/Aunt</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3106 Altair Lane, Upper Marlboro, MD 20774</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cedar Hill Cemetery</b>		Date <b>8/18/2000</b>		20c. Location - City or Town, State <b>Suitland, MD</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>CEDAR HILL FUNERAL HOME, INC. 4111 Pennsylvania Ave., Suitland, MD 20746</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. MULTIPLE INJURIES</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d.</b>								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>8/13/00</b>		28b. Time of Injury <b>0021 A M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>HIGHWAY</b>		28d. Describe how injury occurred <b>PASSENGER OF MOTORCYCLE INVOLVED IN MOTOR VEHICLE ACCIDENT</b> 28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>MD RT 450 AND WHITFIELD CHAPEL RD, LANHAM, MD</b>				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>August 14, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MARY G. RIPLEY, MD 111 Penn Street, Baltimore, Maryland 21201</b>								
31. Date filed (Month, Day, Year) <b>AUG 17 2000</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(5)





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended Item 30 per M.E.

State of Maryland / Department of Health and Mental Hygiene

08/18/2000, Carroll County, wjl

## Certificate of Death

Reg. No.

00 27622

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Claire Rosa Fink				2. Date of Death Month Day Year Aug 14 2000		3. Time of Death 11:51am		
	4a. Facility Name (If not institution, give street and number) Carroll County General Hospital				4b. City, Town, or Location of Death Westminster		4c. County of Death Carroll		
Funeral Director	5. Social Security Number 219-44-9345	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 56 Yrs.	8. Date of Birth (Month, Day, Year) Feb 29 1944	9. Birthplace (State or Foreign Country) PA				
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State MD	10b. County Carroll	10c. City, Town or Location Westminster		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
	10e. Street and Number 94 W. Main Street			10f. Zip Code 21157		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maintenance		16b. Kind of Business/Industry Westminster City Police				
	17. Father's Name (First, Middle, Last) Charles R. Fink				18. Mother's Name (First, Middle, Maiden Surname) Eva Palmer				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mary Crumbie/Sister			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3100 Black Rock Rd Reisterstown, MD 21136					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) St. John Cemetery		Date 8/17		20c. Location - City or Town, State Westminster, MD		
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Pritts Funeral Home and Chapel 412 Washington Rd Westminster, MD 21157					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pulmonary Emboli Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death minutes								
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier 				29c. License number 00051924		29d. Date signed (Month, Day, Year) August 14, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Herbert P. Henderson Jr. MD 2995 Stoner Ave Suite 307 Westminster MD 21157									
31. Date filed (Month, Day, Year) AUG 18 2000		32. Registrar's Signature 							

ORIGINAL



ADH  
PHYLLIS FORREST  
00-4501-031

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27623

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) Phyllis Elaine Forrest		2. Date of Death Month Day Year AUGUST 11, 2000		3. Time of Death 1930 PM	
4a. Facility Name (If not institution, give street and number) 2403 GLENALLEN AVENUE		4b. City, Town, or Location of Death WHEATON		4c. County of Death MONTGOMERY	
5. Social Security Number 577-70-9597		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 48 Yrs.	
8. Date of Birth (Month, Day, Year) Nov. 5, 1951		9. Birthplace (State or Foreign Country) Wash., D.C.			
Usual Residence of Decedent					
10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring	
10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
10e. Street and Number 2403 Glenallen Ave.		10f. Zip Code 20910		10g. Citizen of What Country? United States	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: African American					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Project Coordinator		16b. Kind of Business/Industry Private	
17. Father's Name (First, Middle, Last) James O. McLeod		18. Mother's Name (First, Middle, Maiden Surname) Ruby Hall			
19a. Informant's Name/Relationship (Type, Print) Harvey N. Forrest - Husband		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5113 Brookhaven Ct., Oxon Hill, MD 20745			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Memorial Park		20c. Location - City or Town, State Landover, MD	
20d. Date 8/18/2000					
21. Signature of Funeral Service Licensee John T. Stewart, III		22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  a. Hanging Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):					
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) AT SCENE					
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 8/11/00		28b. Time of Injury (Hour) 7:20 PM	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred SUBJECT HANGED SELF			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Home		28f. Location (Street and Number or Rural Route Number, City or Town, State) 2403 GLENALLEN AVE. WHEATON, MD			
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier J.M. Tins		29c. License number OCME		29d. Date signed (Month, Day, Year) AUGUST 12, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACK M. TINS, M.D. 111 Penn Street, Baltimore, Maryland 21201					
31. Date filed (Month, Day, Year) AUG 17 2000		32. Registrar's Signature B. Spacks			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
perml. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27624

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Ethel Josephine FOX

2. Date of Death

Month Day Year  
August 16, 2000

3. Time of Death

1:08 AM

4a. Facility Name (If not institution, give street and number)

Homewood Retirement Village

4b. City, Town, or Location of Death

Williamsport

4c. County of Death

WASHINGTON

5. Social Security Number

216-22-9036

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

98 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Sep. 8, 1901

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9931 Garis Shop Rd.

10f. Zip Code

21740

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
016a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

George Andrew Snyder

18. Mother's Name (First, Middle, Maiden Surname)

Anna Augusta Snyder

19a. Informant's Name/Relationship (Type, Print)

Gary E. Fox (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13023 Woodburn Rd. Hagerstown, MD 21742

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Rest Haven Cemetery August 19, 2000

Data

20c. Location - City or Town, State

Hagerstown, MD 21742

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

OSBORNE FUNERAL HOME

P.O. Box # 348 Williamsport, MD 21795

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)a. Arteriosclerotic cardiovascular disease year  
Due to (or as a consequence of):Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation, breast cancer.  
stroke, dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D26806

29d. Date signed (Month, Day, Year)

8/16/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Arditha 747 Northern Ave Hagerstown MD 21742

31. Date filed (Month, Day, Year)

AUG 17 2000

32. Registrar's Signature

Beverly B Sparks

State  
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

9-10-00

10-1-01



Tracy Ann Fotino

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #23 PART I, 27 PER MEO

Certificate of Death

Reg. No.

00 27625

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Tracy Ann Fotino</b>				2. Date of Death Month <b>August</b> Day <b>25</b> Year <b>2000</b>				3. Time of Death <b>02:20 P.M.</b>		
	4a. Facility Name (If not institution, give street and number) <b>225 Summit Avenue</b>				4b. City, Town, or Location of Death <b>Hagerstown</b>				4c. County of Death <b>Washington</b>		
Funeral Director	5. Social Security Number <b>212-06-1630</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>29</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>May 14, 1971</b>		9. Birthplace (State or Foreign Country) <b>MA</b>		
	10a. State <b>MD</b>				10b. County <b>Washington</b>		10c. City, Town or Location <b>Hagerstown</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>225 Summit Ave.</b>				10f. Zip Code <b>21740</b>				10g. Citizen of What Country?			
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>1</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Telephones Communications</b>				16b. Kind of Business/Industry <b>Private Business</b>			
17. Father's Name (First, Middle, Last) <b>Arthur Fotino, Jr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Martha R. Smith</b>							
19a. Informant's Name/Relationship (Type, Print) <b>Martha R. Murphy / mother</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>912 Eastham Ct. # 13 Crofton, MD 21114</b>							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Rest Haven Cemetery</b>		Date <b>8/31/00</b>		20c. Location - City or Town, State <b>Hagerstown, MD</b>			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Rest Haven Funeral Chapel 1601 Pennsylvania Ave. Hagerstown, MD 21742</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>ACUTE PNEUMONIA AND CHRONIC ACTIVE HEPATITIS IN ASSOCIATION WITH CHRONIC NARCOTISM</b>				Approximate Interval Between Onset and Death							
Immediate Cause (Final disease or condition resulting in death)				Due to (or as a consequence of):							
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Due to (or as a consequence of):							
				Due to (or as a consequence of):							
				Due to (or as a consequence of):							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
				24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
				24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Scene</b>							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 				29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>August 26, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MARY G. RIPLEY, M.D. 111 Penn Street, Baltimore, Maryland 21201</b>											
31. Date filed (Month, Day, Year) <b>AUG 29 2000</b>				32. Registrar's Signature 							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27626

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HELENE RITCHIE GETTINGS</b>				2. Date of Death Month Day Year <b>AUGUST 16, 2000</b>		3. Time of Death <b>11:27 PM</b>		
	4a. Facility Name (If not Institution, give street and number) <b>WALDORF HEALTH CARE CENTER</b>				4b. City, Town, or Location of Death <b>WALDORF</b>		4c. County of Death <b>CHARLES</b>		
Funeral Director	5. Social Security Number <b>178-09-8670</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>84</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>OCTOBER 20, 1915</b>		
	9. Birthplace (State or Foreign Country) <b>PENNSYLVANIA</b>		10a. State <b>MARYLAND</b>		10b. County <b>CHARLES</b>		10c. City, Town or Location <b>WALDORF</b>		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>6608 COTTONTAIL COURT</b>		10f. Zip Code <b>20603</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOMEMAKER</b>		16b. Kind of Business/Industry <b>OWN HOME</b>		17. Father's Name (First, Middle, Last) <b>DAVID WELLINGTON RITCHIE</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>LETTA EVA WEED</b>	
19a. Informant's Name/Relationship (Type, Print) <b>SANDRA B. WILLIAMS/NIECE</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6608 COTTONTAIL COURT, WALDORF, MARYLAND 20603</b>		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>THE HUNTT CREMATORY</b>		20c. Location - City or Town, State <b>8/17/2000 WALDORF, MARYLAND</b>	
21. Signature of Funeral Service Licensee <i>John P. Knisley</i> <b>JOHN P. KNISLEY</b>		22. Name and Address of Facility <b>THE HUNTT FUNERAL HOME, INC., POST OFFICE BOX 156, WALDORF, MARYLAND 20604-0156</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Amiotrophic Lateral Sclerosis</b> Due to (or as a consequence of):  Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Approximate Interval Between Onset and Death <b>years</b>		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Organic Brain syndrome</b>		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	
28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Charlene A. Letford MD</i>		29c. License number <b>D46419</b>		29d. Date signed (Month, Day, Year) <b>Aug 17, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Charlene A. Letford MD 404 E. Charles St L2 Plote MD 20646</b>		31. Date filed (Month, Day, Year) <b>AUG 21 2000</b>		32. Registrar's Signature <i>Beverly B. Sparks</i>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

JPK

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27627

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ROSEANN MARIE GORMAN

2. Date of Death

Month Day Year  
AUGUST 20, 2000

3. Time of Death

5:05 AM

4a. Facility Name (If not institution, give street and number)

4760 YOUNG ROAD

4b. City, Town, or Location of Death

WALDORF

4c. County of Death

CHARLES

Funeral  
Director

5. Social Security Number

136-36-7483

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

55

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
OCT. 28, 1944

9. Birthplace (State or Foreign Country)

NEW JERSEY

Usual Residence of Decedent

10a. State

MD

10b. County

CHARLES

10c. City, Town or Location

WALDORF

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10a. Street and Number

4760 YOUNG ROAD

10f. Zip Code

20601

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

ADMINISTRATIVE ASSISTANT

16b. Kind of Business/Industry

U.S. GOVERNMENT

17. Father's Name (First, Middle, Last)

FELIX DIPIETRO

18. Mother's Name (First, Middle, Maiden Surname)

MABEL ISODORE

19a. Informant's Name/Relationship (Type, Print)

ROBERT J. GORMAN, JR. - SPOUSE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4760 YOUNG ROAD, WALDORF, MD 20601

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ST. MARY'S CEMETERY

Date

08-24-2000

20c. Location - City or Town, State

BRYANTOWN, MARYLAND

21. Signature of Funeral Service Licensee

MARK G. BROHAWN

M00053

22. Name and Address of Facility

THE HUNTY FUNERAL HOME, INC.  
P.O. BOX 156, WALDORF, MARYLAND 20604

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Malignant Glioblastoma

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1-2 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Charlene A. Letchford

29c. License number

D46419

29d. Date signed (Month, Day, Year)

8/21/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charlene A. Letchford, MD, 404 E. Charles Street, La Plata, MD 20646

31. Date filed (Month, Day, Year)

AUG 22 2000

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27628

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CATHERINE L. GLANDING

2. Date of Death

Month Day Year  
August 19, 2000

3. Time of Death

22:11

4a. Facility Name (If not institution, give street and number)

Kent &amp; Queen Anne's Hospital

4b. City, Town, or Location of Death

Chestertown

4c. County of Death

Kent

Funeral  
Director

5. Social Security Number

219-07-6692

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct 2 1917

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Queen Anne's

10c. City, Town or Location

Millington

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

231 Sassafras St.

10f. Zip Code

21651

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

home

17. Father's Name (First, Middle, Last)

William B. Jump

18. Mother's Name (First, Middle, Maiden Surname)

Florence Johnson

19a. Informant's Name/Relationship (Type, Print)

James Glanding (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 261 Millington, MD. 21651

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Asbury Cemetery

Date

8/23/00

20c. Location - City or Town, State

Millington, MD.

21. Signature of Funeral Service Director

M00510

22. Name and Address of Facility

Galena Funeral Home of Stephen Schaeck  
118 W. Cross St. Galena, MD. 2163523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or head failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Myocardial infarction

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

30 minute

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. End stage decubitus ulcer

Due to (or as a consequence of):

1 month

c. Hypertension

Due to (or as a consequence of):

6 month

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus Type II

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending  
Investigation  
6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

MD

29c. License number

D0051735

29d. Date signed (Month, Day, Year)

8/21/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Frederick Delboy, MD 6602 Church Hill Rd. St. 200 Chestertown, Md 21620

State  
Registrar

31. Date filed (Month, Day, Year)

AUG 21 2000

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural," or items 23a or 23a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
0000.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27629

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Edna F. Gilbert</b>				2. Date of Death Month <b>AUGUST</b> Day <b>20</b> Year <b>2000</b>		3. Time of Death <b>0750</b>	
	4a. Facility Name (If not institution, give street and number) <b>Union Hospital</b>				4b. City, Town, or Location of Death <b>Elkton</b>		4c. County of Death <b>Cecil</b>	
Funeral Director	5. Social Security Number <b>217-50-0070</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>92</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Jan. 9, 1908</b>		9. Birthplace (State or Foreign Country) <b>Louisiana</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Cecil</b>		10c. City, Town or Location <b>Rising Sun</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>116 Post Road</b>				10f. Zip Code <b>21911</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b></b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>		
17. Father's Name (First, Middle, Last) <b>William C. Cowan</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Angie Ellington</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Joyce B. Little/Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2696 Red Toad Road Rising Sun, MD 21911</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Hopewell Cemetery</b>		Date <b>8-23-00</b>		20c. Location - City or Town, State <b>Port Deposit, MD</b>		
21. Signature of Funeral Service Licensee <b>Richard L. Goodie</b>				22. Name and Address of Facility <b>R. T. Foard Funeral Home, P. A. 111 S. Queen St., Rising Sun, MD 21911</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>Metastatic Adenocarcinoma</b> <b>Malignant Pleural Effusion</b>  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Obstructive</b> <b>ITIN</b>								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day Year)		28b. Time of injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and Title of Certifier <b>Stephen E. Ellett MD</b>				29c. License number <b>DD053622</b>		29d. Date signed (Month, Day, Year) <b>8/20/00</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>35 South Main Ave Harre de Grace MD.</b>								
31. Date filed (Month, Day, Year) <b>AUG 22 2000</b>				32. Registrar's Signature <b>B. Sparks</b>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e-I show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27630

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CATHERINE A. GROSS</b>				2. Date of Death Month Day Year <b>August 12 2000</b>		3. Time of Death <b>10:25 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Manor Care Health Services</b>				4b. City, Town, or Location of Death <b>Wheaton</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>579-36-3153</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>71</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>July 21, 1929</b>	
	9. Birthplace (State or Foreign Country) <b>Washington, D.C.</b>		10a. State <b>Washington, D.C.</b>		10b. County		10c. City, Town or Location <b>Washington, D.C.</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>611 Edgewood Terrace, N.E.</b>		10f. Zip Code <b>20017</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Cashier</b>		16b. Kind of Business/Industry <b>Private</b>		17. Father's Name (First, Middle, Last) <b>Fernando Thomas</b>		
18. Mother's Name (First, Middle, Maiden Surname) <b>Katie Briscoe</b>		19a. Informant's Name/Relationship (Type, Print) <b>Valerie B. Hampton/Daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3801 Kennilworth Avenue, Apt #203-E, Bladensburg, MD 20710</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		
20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Fort Lincoln Cemetery</b>		20c. Location - City or Town, State <b>2000 Brentwood, Maryland</b>		21. Signature of Funeral Service Licensee <b>Nancy A. Perente</b>		22. Name and Address of Facility <b>J.B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Breast Cancer</b>  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>{</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		
28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>G. Chablani</b>		
29c. License number <b>D 62518</b>		29d. Date signed (Month, Day, Year) <b>August 14, 2000</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Gul Chablani, M.D., 1119 Rockville Pike, #316, Rockville, Maryland 20852</b>		31. Date filed (Month, Day, Year) <b>AUG 18 2000</b>		
32. Registrar's Signature <b>[Signature]</b>		33. State Registrar <b>[Signature]</b>		34. State Registrar <b>[Signature]</b>		35. State Registrar <b>[Signature]</b>		

ORIGINAL







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State of Maryland / Department of Health and Mental Hygiene

00 27631

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Frank Gomez

2. Date of Death

August 14, 2000

3. Time of Death

2:06 pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital Center

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

5. Social Security Number

281-10-3641

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 6, 1917

9. Birthplace (State or Foreign Country)

New Mexico

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4707 Glenoak Road

10f. Zip Code

20784

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates

WW II thru 12-7-41 thru 7-25-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☒ Yes 2 ☐ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Planner and Estimator

16b. Kind of Business/Industry

Department of Navy

17. Father's Name (First, Middle, Last)

Frank G. Gomez

18. Mother's Name (First, Middle, Maiden Surname)

Vincenza Rojas

19a. Informant's Name/Relationship (Type, Print)

Florence M. Gomez - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4707 Glenoak Road, Hyattsville, MD 20784

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Resurrection Cemetery

Date

8/18/00

20c. Location - City or Town, State

Clinton, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Gasch's Funeral Home, P.A.

4739 Baltimore Avenue, Hyattsville, MD 20781

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Myocardial Infarction

Approximate Interval Between Onset and Death

10 days

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pulmonary Fibrosis Pulmonary

Hypertension Aspiration Pneumonia

Diabetes mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D17572

29d. Date signed (Month, Day, Year)

8/14/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D. Granite, MD 115 Centerway Greenbelt, MD 20770

31. Date filed (Month, Day, Year)

AUG 16 2000

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27632

## Certificate of Death

Reg. No.

Physician (Medical Examiner)	1. Decedent's Name (First, Middle, Last) ELNORA T. GINYARD				2. Date of Death Month Day Year AUGUST 8 2000		3. Time of Death 11:00 AM		
	4a. Facility Name (If not institution, give street and number) DOCTORS COMMUNITY HOSPITAL				4b. City, Town, or Location of Death LANHAM		4c. County of Death PRINCE GEORGES COUNTY		
Funeral Director	5. Social Security Number 578-18-7081		8. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 95 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month Day Year JULY 10, 1905		
	9. Birthplace (State or Foreign Country) SOUTH CAROLINA								
Usual Residence of Decedent									
10a. State MARYLAND		10b. County PRINCE GEORGES		10c. City, Town or Location FORESTVILLE			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 7420 MARLBORO PIKE				10f. Zip Code 20747		10g. Citizen of What Country? UNITED STATES			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: AFRO-AMERICAN		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8TH College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) COOK			16b. Kind of Business/Industry PRIVATE		
17. Father's Name (First, Middle, Last) TIMOTHY TYLER				18. Mother's Name (First, Middle, Maiden Surname) OLIVIA FRANKLIN TYLER					
19a. Informant's Name/Relationship (Type, Print) VERNELL S. HARVEY /NIECE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2110 BROOKS DR. #117, FORESTVILLE, MD 20747					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) LINCOLN MEMORIAL CEM.			Data AUG. 12, 2000		20c. Location - City or Town, State SUITLAND, MD		
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility DUDLEY FUNERAL HOME, MT. RAINIER, MARYLAND 20712					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Staphylococcus Aureus sepsis</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. c. d. Approximate Interval Between Onset and Death Days									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Acute renal failure, upper Gastro-intestinal bleed, Failure to thrive End stage Heart-Disease</i>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier <i>[Signature]</i> M.D.				29c. License number D48213		29d. Date signed (Month, Day, Year) 8-10-2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Neelam Ashai 4000 Mitchellville Rd #220 Bowie MD 20716									
31. Date filed (Month, Day, Year) AUG 15 2000		32. Registrar's Signature <i>[Signature]</i>							

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

00 27633

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Arnell Gaskins, Sr.				2. Date of Death Month Day Year August 9, 2000				3. Time of Death 4:15 P.M.				
	4a. Facility Name (If not institution, give street and number) Prince Georges Hospital Center				4b. City, Town, or Location of Death Cheverly				4c. County of Death Prince Georges				
Funeral Director	5. Social Security Number 239-40-9665		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 66 Yrs.		8. Date of Birth (Month, Day, Year) September 18, 1933		9. Birthplace (State or Foreign Country) North Carolina				
	Usual Residence of Decedent				10a. State Maryland				10b. County Prince Georges		10c. City, Town or Location Bowie		
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 12617 Chanler Lane				10f. Zip Code 20715		10g. Citizen of What Country? U.S.A.		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: Korean		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Manager				16b. Kind of Business/Industry NYC Parks Department				
	17. Father's Name (First, Middle, Last) Albert Gaskins				18. Mother's Name (First, Middle, Maiden Surname) Lena Bell Shepard								
	19a. Informant's Name/Relationship (Type, Print) Linda D. Bishop / Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12617 Chanler Lane Bowie, MD 20715								
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Ft. Lincoln Crematory August 12, 2000 Brentwood, MD				20c. Location - City or Town, State				
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Ft. Lincoln Funeral Home 3401 Bladensburg Rd. Brentwood, MD 20722								
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <u>Terminal Lung Cancer</u> Due to (or as a consequence of): b. <u>Respiratory Failure</u> Due to (or as a consequence of): c. <u>Diabetes mellitus</u> Due to (or as a consequence of): d.  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown								
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 				29c. License number D31528		29d. Date signed (Month, Day, Year) August 11, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Margaret Akpan, M.D. 3308 Dodge Park Rd. Landover, MD 20785													
31. Date filed (Month, Day, Year) AUG 14 2000				32. Registrar's Signature 									

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene

00 27634

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>SANDRA DALE HARDESTY</b>			2. Date of Death Month Day Year <b>August 19, 2000</b>		3. Time of Death <b>2:11PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>7547 Shirley Blvd.</b>			4b. City, Town, or Location of Death <b>Port Tobacco</b>		4c. County of Death <b>Charles</b>		
Funeral Director	5. Social Security Number <b>217-70-7194</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>42</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>August 23, 1957</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>MD</b>		10b. County <b>Charles</b>		10c. City, Town or Location <b>Port Tobacco</b>	
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>7547 Shirley Blvd.</b>		10f. Zip Code <b>20677</b>		
10g. Citizen of What Country? <b>USA</b>		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary <input type="checkbox"/> Secondary (0-12) <input checked="" type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Laborer</b>		16b. Kind of Business/Industry <b>County Dept. of Govt. Enviromental Resources</b>		
17. Father's Name (First, Middle, Last) <b>Walter Lawrence Walker, Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ruth Niomi Lusby Walker</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Jennifer Hardesty/Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5827 Valley Drive St. Leonard, MD 20685</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Resurrection Cemetery</b>		20c. Location - City or Town, State <b>8/24/00 Clinton, Maryland</b>		20d. Date		
21. Signature of Funeral Service Licensee <b>David C. Ehrle</b>		22. Name and Address of Facility <b>AREHART-ECHOLS FUNERAL HOME, P.A. P.O. BOX 567 LA PLATA, MD 20646</b>		22. Name and Address of Facility		22. Name and Address of Facility		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>BREAST CANCER</b>		Due to (or as a consequence of):		Due to (or as a consequence of):		Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Due to (or as a consequence of):		Due to (or as a consequence of):		Due to (or as a consequence of):		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA <input type="checkbox"/> Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>M</b>		
28b. Time of Injury		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Kenise M. Maltz</b>		29c. License number <b>028352</b>		
29d. Date signed (Month, Day, Year) <b>8/24/00</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Krishan Mathur, M.D. 3500 Old Washington Rd. Suite 103 Waldorf, MD 20602</b>		31. Date filed (Month, Day, Year) <b>AUG 21 2000</b>		32. Registrar's Signature <b>B. Sparks</b>		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27635

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOSEPH CLARENCE HILL

2. Date of Death

August 16 2000

3. Time of Death

8:12 PM

4a. Facility Name (If not institution, give street and number)

Civista Medical Center

4b. City, Town, or Location of Death

LaPlata

4c. County of Death

Charles

Funeral  
Director

5. Social Security Number

213-38-4483

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

August 14, 1926

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Charles

10c. City, Town or Location

La Plata

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

One Magnolia Drive

10f. Zip Code

20646

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Farming

17. Father's Name (First, Middle, Last)

John Walter Hill

18. Mother's Name (First, Middle, Maiden Surname)

Loretta Toye Hill

19a. Informant's Name/Relationship (Type, Print)

Patricia Thomas/Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

627 Hemlock Court La Plata, MD 20646

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cem. Holy Ghost Catholic

Date

8/24/00

20c. Location - City or Town, State

Issue, Maryland

21. Signature of Funeral Service Licensee

David C. Echols M00945

22. Name and Address of Facility

AREHART-ECHOLS FUNERAL HOME, P.A.  
P.O. BOX 567 LA PLATA, MD. 20646

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

Cerebrovascular accident

30 min

Due to (or as a consequence of):

b.

Cardiac arrhythmia

2 hr

Due to (or as a consequence of):

c.

Coronary artery disease

10 yrs

Due to (or as a consequence of):

d.

Hypertension

25 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Paul E. Pritchett, M.D.

29c. License number

D-008370

29d. Date signed (Month, Day, Year)

8/17/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paul E. Pritchett, M.D.

118 LaGrange Ave. P.O. Box 1317  
LaPlata, Maryland 20646State  
Registrar

31. Date filed (Month, Day, Year)

AUG 21 2000

32. Registrar's Signature

Benjamin B. Sparks

ORIGINAL

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1902 April

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27636

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DAVID FRANKLIN HOWELLS

2. Date of Death

Day Year

August 20, 2000

3. Time of Death

11:20 p.m.

4a. Facility Name (If not institution, give street and number)

6165 Ripley Way

4b. City, Town, or Location of Death

LaPlata

4c. County of Death

Charles

Funeral  
Director

5. Social Security Number

169-28-7760

6. Sex

XXM 2 ☐ F

7. Age (In yrs. last birthday)

67

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

July 29, 1933

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Charles

10c. City, Town or Location

LaPlata

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6165 Ripley Way

10f. Zip Code

20646

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Navar Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 1954-1956

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

Collega (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Lucent Tech.

16b. Kind of Business/Industry

Corporation

17. Father's Name (First, Middle, Last)

Aurthur Luellen Howells

18. Mother's Name (First, Middle, Maiden Surname)

Agnes Milchinski

19a. Informant's Name/Relationship (Type, Print)

Phyllis Howells Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Same as #10

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

August 22, 2000  
Metropolitan Funeral Service, Inc. Alexandria, Virginia

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Williams Funeral Home, P.A.

M00668 4270 Hawthorne Rd., Indian Head, Maryland 20640

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Multiple Myeloma  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 years

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicida 4 ☐ Homicida

28a. Date of Injury (Month, Day, Year)

28b. Time of injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M-A. MEELU MD 10 ST. PATRICKS DRIVE Waldorf MD 20603

MD 20603

State  
Registrar

31. Date filed (Month, Day, Year)

AUG 21 2000

32. Registrar's Signature

Benita B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27637

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Pauline Hall</b>				2. Date of Death Month <b>08</b> Day <b>13</b> Year <b>2000</b>				3. Time of Death <b>8:30pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>Magnolia Center</b>				4b. City, Town, or Location of Death <b>Lanham</b>				4c. County of Death <b>Prince George's</b>	
Funeral Director	5. Social Security Number <b>578-60-0424</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>72</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>10-8-1927</b>		9. Birthplace (State or Foreign Country) <b>Washington, DC</b>	
	10a. State <b>MD</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Forestville</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>1869 S. Addison Road</b>		10f. Zip Code <b>20747</b>				10g. Citizen of What Country? <b>United States</b>				
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>0</b> College (1-4or 5+) <b>0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Unemployed</b>				16b. Kind of Business/Industry <b>N/A</b>				
17. Father's Name (First, Middle, Last) <b>Leroy Hall</b>				18. Mother's Name (First, Middle, Maiden Summa) <b>Venus Jannie</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Bernice Darby, Sister</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2512 Darel Dr. #T1, Suitland, Md. 20746</b>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Forest Hills Cem.</b>				20c. Location - City or Town, State <b>8-18-2000 Clinton, Md.</b>				
21. Signature of Funeral Service Licensee <b>Ralph Williams 767</b>				22. Name and Address of Facility <b>Ralph Williams Funeral Service 517 11th St., SE, Wash., DC 20003</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Myocardial Infarction</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Peripheral Vascular Disease</b> <b>Chronic Renal failure</b> <b>Anemia</b>				Approximate Interval Between Onset and Death <b>5 minutes</b>						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Peripheral Vascular Disease</b> <b>Chronic Renal failure</b> <b>Anemia</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>William DuBayce, MD</b>				29c. License number <b>047603</b>		29d. Date signed (Month, Day, Year) <b>08/16/00</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>William DuBayce, MD 4000 Mitchellville Rd B216 Bowie, MD</b>										
31. Date filed (Month, Day, Year) <b>AUG 18 2000</b>				32. Registrar's Signature <b>B. Sparks</b>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

11







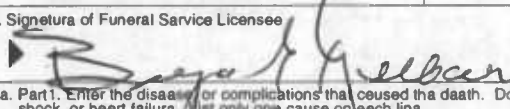
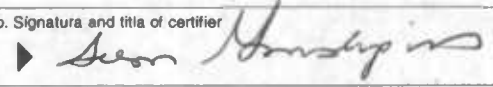

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27639

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Grace Elizabeth Hawkins				2. Date of Death Month Day Year August 12, 2000		3. Time of Death 2:55 P.M.	
	4a. Facility Name (If not institution, give street and number) Independence Court Assisted Living				4b. City, Town, or Location of Death HYATTSVILLE		4c. County of Death PRINCE GEORGES	
Funeral Director	5. Social Security Number 577-60-5873	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	8. Date of Birth (Month, Day, Year) December 27, 1919	9. Birthplace (State or Foreign Country) Washington, DC			
	Usual Residence of Decedent							
10a. State		10b. County		10c. City, Town or Location Washington, D.C.		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 4910 Illinois Ave. N.W.				10f. Zip Code 20011		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk		16b. Kind of Business/Industry U.S. Government		
17. Father's Name (First, Middle, Last) James Campbell				18. Mother's Name (First, Middle, Maiden Surname) Araminta Frye				
19a. Informant's Name/Relationship (Type, Print) Roland Brack / Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1242 Aspen St. NW Washington, DC 20012				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Ft. Lincoln Cemetery August 16, 2000 Brentwood, MD		20c. Location - City or Town, State		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Ft. Lincoln Funeral Home 3401 Bladensburg Rd. Brentwood, MD 20722				
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Renal failure Due to (or as a consequence of): Metastatic lung cancer  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number 12879		29d. Date signed (Month, Day, Year) August 15, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Susan Ginsberg, M.D. 106 Irving St. NW #409 Washington, DC 20010								
31. Date filed (Month, Day, Year) AUG 16 2000				32. Registrar's Signature 				





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27640

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ISAAC NIGEL HYMAN</b>				2. Date of Death Month <b>August</b> Day <b>10</b> Year <b>2000</b>				3. Time of Death <b>09:08 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>7302 Calder Drive</b>				4b. City, Town, or Location of Death <b>Capitol Heights</b>				4c. County of Death <b>Prince George's</b>	
Funeral Director	5. Social Security Number <b>215-35-5558</b>		6. Sex <b>1</b> M <b>2</b> F		7. Age (In yrs. last birthday) <b>19</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Oct. 29, 1980</b>		9. Birthplace (State or Foreign Country) <b>Washington, DC</b>	
	Usual Residence of Decedent				10a. State <b>Maryland</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Capitol Heights</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number <b>7302 Calder Drive</b>				10f. Zip Code <b>20743</b>	
	10g. Citizen of What Country? <b>U.S.A.</b>				11. Marital Status <b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> Yes <b>2</b> No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> Yes <b>2</b> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>College</b>	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Construction</b>				16b. Kind of Business/Industry <b>Private Industry</b>				17. Father's Name (First, Middle, Last) <b>Marvin Hyman</b>	
	18. Mother's Name (First, Middle, Maiden Surname) <b>Bernadette Whitfield</b>				19a. Informant's Name/Relationship (Type, Print) <b>Marvin Hyman - Father</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7302 Calder Drive, Capitol Heights, MD 20743</b>	
	20a. Method of Disposition <b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Forest Hills Cemetery</b>				20c. Location - City or Town, State <b>8-17-00 Clinton, Maryland</b>	
	21. Signature of Funeral Service Licensee <b>Julia P. Marshall</b>				22. Name and Address of Facility <b>Marshall's Funeral Home, Inc.</b> <b>4217 9th Street N.W. Washington DC 20011</b>				23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>CONTACT GUNSHOT WOUND OF HEAD</b>	
	23b. Did tobacco use contribute to the cause of death? <b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown				24a. Was an autopsy performed? <b>1</b> Yes <b>2</b> No				24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> Yes <b>2</b> No	
	25. Was case referred to medical examiner? <b>1</b> Yes <b>2</b> No				26. Place of Death (Check only one) Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify) <b>Scene</b>				27. Manner of Death <b>1</b> Natural <b>2</b> Accident <b>3</b> Suicide <b>4</b> Homicide <b>5</b> Pending Investigation <b>6</b> Could not be determined	
	28a. Date of Injury (Month, Day, Year) <b>AUG. 10, 2000</b>				28b. Time of Injury <b>2050 P.M.</b>				28c. Injury at Work? <b>1</b> Yes <b>2</b> No	
28d. Describe how injury occurred <b>SUBJECT SHOT HIMSELF</b>				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>HOME</b>				28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>7302 CALDER DRIVE CAPITOL HIGHT. MD.</b>		
State Registrar	29a. Certifier (Check only one) <b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <b>Dennis Chute</b>				29c. License number <b>O.C.M.E.</b>	
	29d. Date signed (Month, Day, Year) <b>August 11, 2000</b>				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dennis Chute M.D. 111 Penn Street, Baltimore, Maryland 21201</b>				31. Date filed (Month, Day, Year) <b>AUG 16 2000</b>	
	32. Registrar's Signature <b>[Signature]</b>									

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

00 27641

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Henry F.X. Hession</b>				2. Date of Death Month Day Year <b>AUG 13 2000</b>				3. Time of Death <b>8:39 P.M.</b>							
	4a. Facility Name (If not institution, give street and number) <b>MALCOLM GROW MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>CAMP SPRINGS</b>				4c. County of Death <b>PRINCE GEORGE'S</b>							
Funeral Director	5. Social Security Number <b>110-09-4370</b>		6. Sex <b>XX</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>81</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Sept. 17, 1918</b>		9. Birthplace (State or Foreign Country) <b>Brooklyn, N.Y.</b>							
	Usual Residence of Decedent															
10a. State <b>Maryland</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Fort Washington</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
10e. Street and Number <b>9303 Ivanhoe Road</b>				10f. Zip Code <b>20744</b>				10g. Citizen of What Country? <b>USA</b>								
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>Retired 1974</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>								
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Officer US Air Force</b>				16b. Kind of Business/Industry <b>Military</b>								
17. Father's Name (First, Middle, Last) <b>Henry F. Hession</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Theodosia Behr</b>												
19a. Informant's Name/Relationship (Type, Print) <b>June S. Hession/Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Same as item 10</b>												
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arlington National Cem. 8/21/2000 Arlington, VA.</b>				20c. Location - City or Town, State								
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd. Oxon Hill, Md. 20745</b>												
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																
<table border="1"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>e. <b>PNEUMONIA</b></td> <td rowspan="4">           Due to (or as a consequence of):             Due to (or as a consequence of):             Due to (or as a consequence of):             Due to (or as a consequence of):         </td> <td rowspan="4">           Approximate Interval Between Onset and Death   <b>48 HOURS</b> </td> </tr> <tr><td></td></tr> <tr><td></td></tr> <tr><td></td></tr> </table>										Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e. <b>PNEUMONIA</b>	Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	Approximate Interval Between Onset and Death  <b>48 HOURS</b>			
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e. <b>PNEUMONIA</b>	Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	Approximate Interval Between Onset and Death  <b>48 HOURS</b>													
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)												
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred								
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																
29b. Signature and title of certifier 				29c. License number <b>VA 0101056740</b>				29d. Date signed (Month, Day, Year) <b>AUGUST 13 2000</b>								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>PETER J. CURRAN, CAPT, USAF, MD</b> <b>89 MDG/1050 W PERIMETER ROAD</b> <b>ANDREWS AIR FORCE BASE MD 20762</b>																
31. Date filed (Month, Day, Year) <b>AUG 15 2000</b>				32. Registrar's Signature 												

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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State of Maryland / Department of Health and Mental Hygiene

00 27642

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>James Pearce Hope</i>				2. Date of Death Month <i>August</i> Day <i>16</i> Year <i>2000</i>		3. Time of Death <i>0525</i>		
	4a. Facility Name (If not institution, give street and number) <i>Washington County Hospital</i>				4b. City, Town, or Location of Death <i>Hagerstown</i>		4c. County of Death <i>Washington</i>		
Funeral Director	5. Social Security Number <i>103-12-0052</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <i>79</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>Dec. 11, 1920</i>		
	9. Birthplace (State or Foreign Country) <i>Wash. D. C.</i>		10a. State <i>Maryland</i>		10b. County <i>Washington</i>		10c. City, Town or Location <i>Hagerstown</i>		
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number <i>Ravenwood Nursing Home</i>		10f. Zip Code <i>21740</i>		
	10g. Citizen of What Country? <i>USA</i>				11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <i>white</i>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>8</i> College (1-4 or 5+) <i>0</i>		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>dock worker</i>				16b. Kind of Business/Industry <i>railroad</i>				
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <i>Vernon Hope</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Blanche Pearce</i>				
	19a. Informant's Name/Relationship (Type, Print) <i>Michael A. Jones - cousin</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>831 Maryland Ave., Hagerstown, Md. 21740</i>				
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Hagerstown Crematory</i>		20c. Location - City or Town, State <i>8-17-2000 Hagerstown, Maryland</i>		
	21. Signature of Funeral Service Licensee <i>Scott M. Minnich</i>				22. Name and Address of Facility <i>MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740</i>				
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>a. right sided cerebrovascular accident</i> Due to (or as a consequence of): <i>b. metastatic cancer in brain</i> Due to (or as a consequence of): <i>c. end stage renal disease on hemodialysis</i> Due to (or as a consequence of): <i>d. blindness, glaucoma</i>							Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>		
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28d. Describe how injury occurred				
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier <i>Yn. MD</i>				29c. License number <i>BY 6111823</i>		29d. Date signed (Month, Day, Year) <i>August 16, 2000</i>		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Yanping Yu, 12931 Oakhill Ave. Hagerstown - MD. 21742</i>								
To Be Completed by Physician/Medical Examiner	31. Date filed (Month, Day, Year) <i>AUG 17 2000</i>				32. Registrar's Signature <i>[Signature]</i>				
	State Registrar								

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27643

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EMMA JANE HARVEY				2. Date of Death Month Day Year AUGUST 16, 2000		3. Time of Death 6:46 PM	
	4a. Facility Name (If not institution, give street and number) HOMEWOOD OF WILLIAMSPORT				4b. City, Town, or Location of Death WILLIAMSPORT		4c. County of Death WASHINGTON	
Funeral Director	5. Social Security Number 232-36-9355		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 98 Yrs.		8. Date of Birth (Month, Day, Year) 7/19/1902	
	Usual Residence of Decedent		10a. State WV		10b. County JEFFERSON		10c. City, Town or Location SHEPHERDSTOWN	
10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 601 LITTLE RUN ACRES		10f. Zip Code 25443		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 11		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PACKING		16b. Kind of Business/Industry GLASS PRODUCTION				
17. Father's Name (First, Middle, Last) JOHN HADDEN STALNAKER				18. Mother's Name (First, Middle, Maiden Surname) MINNIE FISHER				
19a. Informant's Name/Relationship (Type, Print) PATRICIA KACKLEY / FRIEND				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3207 APPLE BLOSSOM TERRACE, MARTINSBURG, WV 25401				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MACHPELAH CEMETERY		20c. Location - City or Town, State WESTON, WV		20d. Date 8/19/00		
21. Signature of Funeral Service Licensee Charles M. Brown				22. Name and Address of Facility BROWN FUNERAL HOME, 327 W. KING ST., PO BOX 821, MARTINSBURG, WV 25402				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. ACUTE RENAL FAILURE Due to (or as a consequence of): b. POOR ORAL INTAKE Due to (or as a consequence of): c. SENILE DEMENTIA Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death 1 WEEK TWO WEEKS TWO-THREE YEARS						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CORONARY ARTERY DISEASE. TACHY-BRADY SYNDROME. PACEMAKER MALFUNCTION. PULMONARY HYPERTENSION						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 8 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and Title of certifier The Hon. Medical Director		29c. License number D17067		29d. Date signed (Month, Day, Year) 8/17/2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STEPHEN E. HAGENSTADT, MD 747 NORTHERN AVE. HAGENSTADT, MD								
31. Date filed (Month, Day, Year) AUG 21 2000		32. Registrar's Signature Benjamin B. Sparks						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27644

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Kathryn Marie Harris</b>					2. Date of Death Month <b>August</b> Day <b>19</b> Year <b>2000</b>			3. Time of Death <b>9:31 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Avalon Manor Health Care Center</b>					4b. City, Town, or Location of Death <b>Hagerstown</b>			4c. County of Death <b>Washington</b>	
Funeral Director	5. Social Security Number <b>220-16-0180</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>73</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Oct. 6, 1926</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>Md.</b>		10b. County <b>Washington</b>		10c. City, Town or Location <b>Smithsburg</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>22824 Jefferson Blvd. P.O. Box 522</b>				10f. Zip Code <b>21783</b>		10g. Citizen of What Country? <b>U.S.A</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b></b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Seamstress</b>				16b. Kind of Business/Industry <b>Dress Factory</b>			
	17. Father's Name (First, Middle, Last) <b>Harry David Kaetzel</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Bernadet Rebecca Cramer</b>				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Arthur E. Harris (Husband)</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>22824 Jefferson Blvd. Smithsburg, Md. 21783 P.O. Box 522</b>				
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Smithsburg Crematory</b>			Date <b>Aug. 21, 2000</b>		20c. Location - City or Town, State <b>Smithsburg, Md.</b>		
	21. Signature of Funeral Service Licensee <i>[Signature]</i>					22. Name and Address of Facility <b>Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Md. 21783</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
23c. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
23d. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Arterio-sclerotic Cardiovascular Disease</b> <b>Coronary Artery Disease Right Ventricle</b> <b>Constrictive Heart Failure</b>										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <b>D 18019</b>		29d. Date signed (Month, Day, Year) <b>Aug 21, 2000</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Vasant Datta 334 Mill Street Hagerstown, MD 21740</b>										
31. Date filed (Month, Day, Year) <b>AUG 22 2000</b>		32. Registrar's Signature <i>[Signature]</i>								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene 00 27645

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Leroy Wilbur Hart</b>				2. Date of Death Month <b>Aug.</b> Day <b>17</b> , Year <b>2000</b>		3. Time of Death <b>17:38</b>	
	4a. Facility Name (If not institution, give street and number) <b>Washington County Hospital</b>				4b. City, Town, or Location of Death <b>Hagerstown,</b>		4c. County of Death <b>Washington</b>	
Funeral Director	5. Social Security Number <b>215-44-7667</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>57</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>June 21, 1943</b>		9. Birthplace (State or Foreign Country) <b>MD</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>Washington</b>		10c. City, Town or Location <b>Clear Spring,</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>12929 National Pike</b>			10f. Zip Code <b>21722</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th grade</b> College (1-4 or 5+) <b>0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>laborer</b>			16b. Kind of Business/Industry <b>towing company</b>		
	17. Father's Name (First, Middle, Last) <b>Clyde W. Hart</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Alice V. Hart</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Faye V. Burgan sister</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12711 Spickler Rd. Clear Spring, MD 21722</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Shanktown Cemetery</b>		Date <b>Aug. 21, 2000</b>		20c. Location - City or Town, State <b>Big Pool, MD</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Donald Edwin Thompson Funeral Home, Inc P.O. BOX 310 Clear Spring, MD 21722</b>			
	23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Cerebrovascular Accident</b> Due to (or as a consequence of): <b>b. Metastatic Colon Cancer</b> Due to (or as a consequence of): <b>c. Intrabdominal Sepsis</b> Due to (or as a consequence of): <b>d.</b>							
	23b. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>c. Intrabdominal Sepsis</b> Due to (or as a consequence of): <b>d.</b>							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						
		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number <b>D44471</b>		29d. Date signed (Month, Day, Year) <b>08/17/00</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>ILANA WEST 1110 MEDICAL CAMARUS RD. HAGERSTOWN, MD. 21742 #100</b>								
31. Date filed (Month, Day, Year) <b>AUG 22 2000</b>		32. Registrar's Signature 						





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27646

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Cleola Jacobs

2. Date of Death

August 13 2000

3. Time of Death

6:50 a.m.

4a. Facility Name (If not institution, give street and number)

Gladys Spellman Nursing Home

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince Georges

Funeral  
Director

5. Social Security Number

578-60-1654

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

67

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 2, 1933

9. Birthplace (State or Foreign Country)

NC

Usual Residence of Decedent

10a. State

DC

10b. County

10c. City, Town or Location

Washington

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3847 8th St., SE

10f. Zip Code

20032

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Real Estate Broker

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Ezelle James Jacobs, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Isabell Peterson

19a. Informant's Name/Relationship (Type, Print)

Felicia Reynolds

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3847 8th St., SE Washington, DC 20032

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Riverdale Park Crematory

Date

Aug 19, 00

20c. Location - City or Town, State

Riverdale, MD 20737

21. Signature of Funeral Service Licensee

Beha J. Jenkins

22. Name and Address of Facility

Johnson &amp; Jenkins Funeral Home

716 Kennedy St., NW Washington, DC 20011

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Sepsis

Due to (or as a consequence of):

days

c. Diabetes Mellitus

Due to (or as a consequence of):

years

d. Multiple Decubital Ulcers

WKS-Month

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension, Peripheral Vascular

Psychosis, schizophrenia disorder

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

J. M.D.

29c. License number

D0056184

29d. Date signed (Month, Day, Year)

August 14th, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jahid Saied, MD, 3001 Hospital Dr., Cheverly, MD 20785

31. Date filed (Month, Day, Year)

AUG 17 2000

32. Registrar's Signature

B. B. Smith

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27647

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>Martha F. Kla</b>		2. Date of Death Month <b>8</b> Day <b>16</b> Year <b>2000</b>		3. Time of Death <b>4:59 AM</b>	
4a. Facility Name (If not institution, give street and number) <b>Washington Adventist Hospital</b>			4b. City, Town, or Location of Death <b>Takoma Park</b>		4c. County of Death <b>Montgomery</b>
5. Social Security Number <b>218-41-2425</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>64</b> Yrs.	If Under 1 Year Months Days	8. Date of Birth (Month, Day, Year) <b>9-9-1935</b>	9. Birthplace (State or Foreign Country) <b>West Africa</b>
Usual Residence of Decedent					
10a. State <b>Maryland</b>	10b. County <b>Montgomery</b>	10c. City, Town or Location <b>Silver Spring</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number <b>8860 Piney Branch Rd. #1505</b>			10f. Zip Code <b>20903</b>		10g. Citizen of What Country? <b>Liberia</b>
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>N/A</b> College (1-4 or 5+) <b>Housewife</b>			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Housewife</b>		16b. Kind of Business/Industry <b>Private</b>			
17. Father's Name (First, Middle, Last) <b>Samuel Kla</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Grace Nyenplu</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Baj Kla / Son</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8220 Greenspire Terrace, Adelphi, MD. 20783</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>George Washington Cem.</b>		20c. Location - City or Town, State <b>8/18/00 Adelphi, MD.</b>	
21. Signature of Funeral Service Licensee <i>Katharine Myers</i>			22. Name and Address of Facility <b>Pope Funeral Homes</b> <b>5538 Marlboro Pike, Forestville, MD. 20747</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Atherosclerotic Coronary Artery Disease</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier <i>Lawrence Simon MD</i>			29c. License number <b>D36177</b>		29d. Date signed (Month, Day, Year) <b>August 16, 2000</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Lawrence Simon, 7600 Carroll Ave. Takoma Park, MD. 20912</b>					
31. Date filed (Month, Day, Year) <b>AUG 18 2000</b>		32. Registrar's Signature <i>Bernice B. Smith</i>			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27648

Certificate of Death

Reg. No.

Per PB

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

3

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>AISSAM KAZAMA</b>				2. Date of Death Month <b>AUGUST</b> Day <b>16</b> Year <b>2000</b>				3. Time of Death <b>10:40 PM</b>	
4a. Facility Name (If not institution, give street and number) <b>National Institute of Health</b>				4b. City, Town, or Location of Death <b>Bethesda</b>				4c. County of Death <b>Montgomery</b>	
5. Social Security Number <b>None</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>16</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>March 10, 1984</b>		9. Birthplace (State or Foreign Country) <b>Morocco</b>	
Usual Residence of Decedent									
10a. State <b>Morocco</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Menara</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>32 LOT IKI 5</b>				10f. Zip Code <b>00000</b>				10g. Citizen of What Country? <b>Morocco</b>	
11. Marital Status <input checked="" type="checkbox"/> Navar Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>Moroccan</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>unknown</b> College (1-4or 5+) <b>Student</b>				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>School</b>				16b. Kind of Business/Industry	
17. Father's Name (First, Middle, Last) <b>Mohamed Kazama</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Bani Touria</b>					
19a. Intorment's Name/Relationship (Type, Print) <b>Mohamed Kazama - Father</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>32 LOT IKI 5, Menara, Morocco</b>					
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Marrakech Morocco</b>				20c. Location - City or Town, State <b>8-21-00 Menara, Morocco</b>	
21. Signature of Funeral Service Licensee <b>Jubia P. Marshall</b>				22. Name and Address of Facility <b>Marshall's Funeral Home, Inc. 4217 9th Street N.W. Washington, DC 20011</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>hypoxia</b> Due to (or as a consequence of):  b. <b>pulmonary hemorrhage</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.								Approximate Interval Between Onset and Death  <b>10h</b>  <b>10h</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.  <b>Neutropenia, Aspergillus</b> <b>CML, s/p Bone marrow transplant.</b>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred					
28e. Location (Street and Number or Rural Route Number, City or Town, State)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <b>[Signature]</b>				29c. License number <b>OH10 35-07-1658-B</b>	
29d. Date signed (Month, Day, Year) <b>8/16/00</b>				30. Name and address of person who completed causa of death (Item 23a) (Type, Print) <b>JOHN BEIGEL 9000 ROCKVILLE PIKE, BETHESDA, MARYLAND 20892</b>					
31. Data filed (Month, Day, Year) <b>AUG 18 2000</b>				32. Registrar's Signature <b>[Signature]</b>					





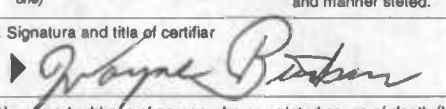

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27649

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Margaret Armstrong Klotz</b>		2. Date of Death Month <b>August</b> Day <b>11</b> Year <b>2000</b>		3. Time of Death <b>9:AM</b>
	4a. Facility Name (If not institution, give street and number) <b>516 Lankford Rd.</b>		4b. City, Town, or Location of Death <b>Harwood</b>		4c. County of Death <b>Anne Arundel</b>
Funeral Director	5. Social Security Number <b>219-76-0850</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>88</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>Feb. 12, 1912</b>		9. Birthplace (State or Foreign Country) <b>Virginia</b>		
Usual Residence of Decedent					
10a. State <b>Maryland</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Harwood</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <b>516 Lankford Road</b>		10f. Zip Code <b>20776</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>N/A</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Home</b>	
17. Father's Name (First, Middle, Last) <b>Edgar Armstrong</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Susan Bryant</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Margaret Mitchell (Daughter)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>510 Lankford Road, Harwood, Md. 20776</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Ramoth Baptist Church Cem.</b>		20c. Location - City or Town, State <b>Stafford, Virginia</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Lee Funeral Home, INC</b> <b>6633 Old Alexander Ferry Rd. Clinton, Md. 20735</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		a. <b>Hypoxia</b> Due to (or as a consequence of):		1 Hr.	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. <b>Aspiration Pneumonia</b> Due to (or as a consequence of):		6 Hrs.	
		c. <b>Right Cerebral Vascular Accident</b> Due to (or as a consequence of):		1 Yr.	
		d.			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Dementia</b>					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number <b>D38563</b>		29d. Date signed (Month, Day, Year) <b>August 15, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Wayne D. Bierbaum, M.D. 134 Owensville Rd. West River, Md.</b>					
31. Date filed (Month, Day, Year) <b>AUG 16 2000</b>		32. Registrar's Signature 			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27650

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARY RIDO KEES

2. Date of Death

Month  
AUGUSTDay  
7,Year  
2000

3. Time of Death

7:30 PM

4e. Facility Name (If not institution, give street and number)

HOMWOOD NURSING HOME

4b. City, Town, or Location of Death

WILLIAMSPORT

4c. County of Death

WASHINGTON

5. Social Security Number

332-28-7795

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
7/14/1912

9. Birthplace (State or Foreign Country)

WASHINGTON

Usual Residence of Decedent

10e. State

WV

10b. County

BERKELEY

10c. City, Town or Location

MARTINSBURG

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

202 SHENANDOAH RD., APT. 1B

10f. Zip Code

25401

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

ANDRE CRISCUOLO

18. Mother's Name (First, Middle, Maiden Surname)

MARIA RIDO

19e. Informant's Name/Relationship (Type, Print)

VIOLA K. HARGETT/ADM. ESTATE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

119 RETIREMENT LANE, MARTINSBURG, WV 25401

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

CHRIST REFORMED CEMETERY

Date

8/18/00

20c. Location - City or Town, State

SHEPHERDSTOWN, WV

21. Signature of Funeral Service Licensee

Charles M. Brown

22. Name and Address of Facility

BROWN FUNERAL HOME, 327 W. KING ST.  
PO BOX 821, MARTINSBURG, WV 25402

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic cardiovascular disease year

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia, dysphagia, Atrial Fibrillation

Chronic obstructive lung disease

Coronary artery disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D26806

29d. Date signed (Month, Day, Year)

8/9/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Allen W. D. Hays 747 Northern Ave Hagerstown MD 21742

31. Date filed (Month, Day, Year)

AUG 18 2000

32. Registrar's Signature

[Signature]

State

Registrar

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27651

Amended Item#9 per INFG787 9/18/2000 EW

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Beverly Grigsby Lucas

2. Date of Death  
Month Day Year

8 11 2000

3. Time of Death

1:00 pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

4400 Dilworth Place

4b. City, Town, or Location of Death

Upper Marlboro

4c. County of Death

PG

5. Social Security Number

579-42-7660

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

71

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

1-18-1929

9. Birthplace (State or Foreign Country)

WASH. DC

Virginia

Usual Residence of Decedent

10a. State

DC

10b. County

10c. City, Town or Location

Washington

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1507 Morris Road SE

10f. Zip Code

20020

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No

Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12th

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Telephone Operator

16b. Kind of Business/Industry

DC Government

17. Father's Name (First, Middle, Last)

George Grigsby

18. Mother's Name (First, Middle, Maiden Surname)

Doris Tuckson

19a. Informant's Name/Relationship (Type, Print)

B. Preston Lucas

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1507 Morris Road SE Washington, DC 20020

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Olivet Cemetery

Date

8/16/00

20c. Location - City or Town, State

Washington, DC

21. Signature of Funeral Service Licensee

Reginald E. Collier

22. Name and Address of Facility

Wm. F. Magruder 2311 MLK Jr. Ave SE WDC

20020

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC ENDOMETRIAL ADENOCARCINOMA

8 MONTHS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate Cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

Long Rd

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Susan H. Houseman

29c. License number

DC 9603

29d. Date signed (Month, Day, Year)

8-18-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SUSAN H. HOUSEMAN 2100 W. PA AVE NW WASH. DC 20037

31. Date filed (Month, Day, Year)

AUG 18 2000

32. Registrar's Signature

B. Smith

State  
Registrar

Baltimore, Maryland 21215-0020

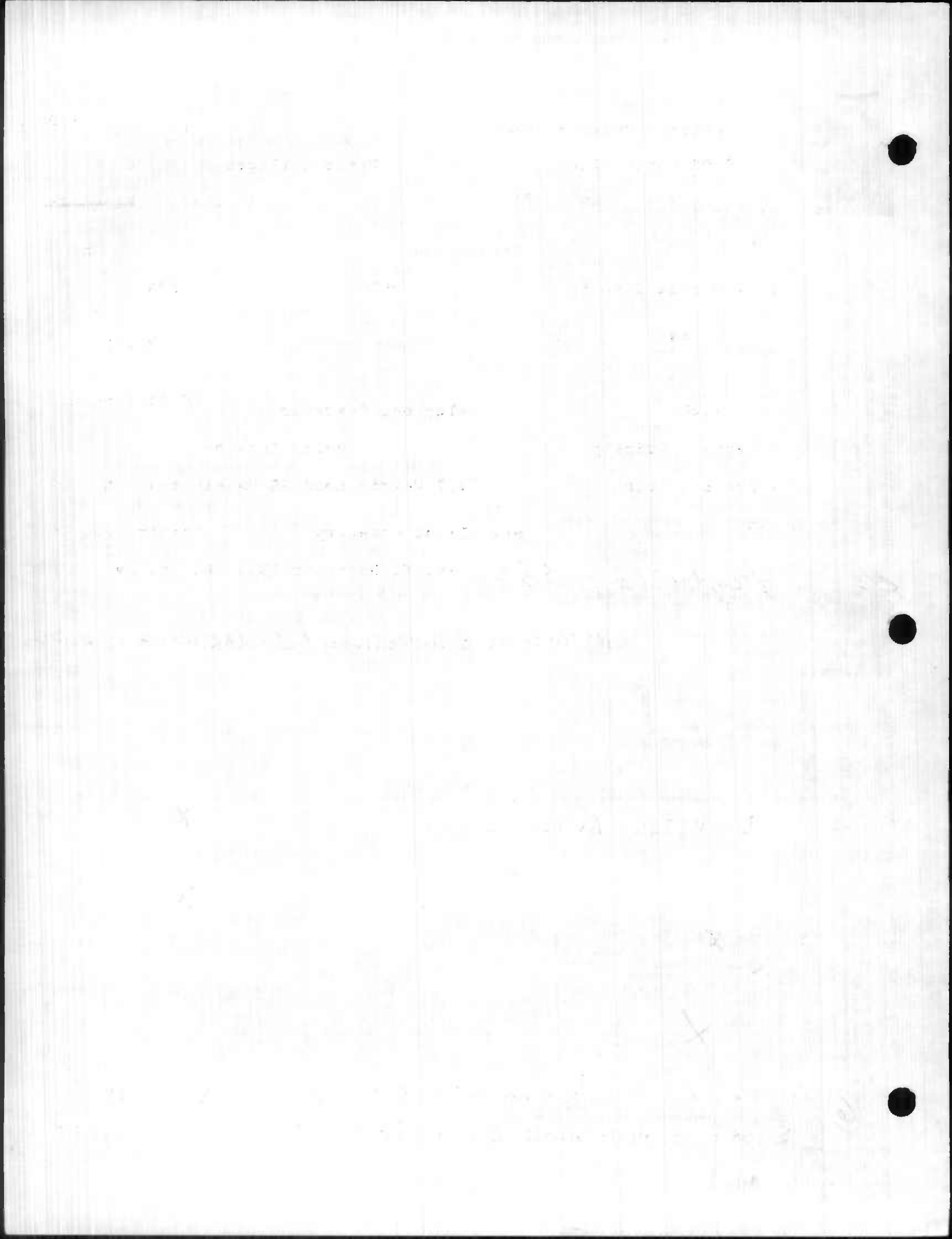
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit case.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27652

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mildred Lewis

2. Date of Death

Month Day Year  
Aug. 15, 2000

3. Time of Death

9:30AM

4a. Facility Name (If not institution, give street and number)

Laurel Regional Hospital

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Prince Georges

Funeral  
Director

5. Social Security Number

577-12-4137

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Jan. 30, 1912

9. Birthplace (State or Foreign Country)

Washington

Usual Residence of Decedent

10a. State

Md.

10b. County

Prince Georges

10c. City, Town or Location

Bowie

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

12508 Chelton Lane

10f. Zip Code

20715

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clerical

16b. Kind of Business/Industry

Government

17. Father's Name (First, Middle, Last)

Unknown

18. Mother's Name (First, Middle, Maiden Surname)

Mary Franklin

19a. Informant's Name/Relationship (Type, Print)

Miriam A. Jamison-Pinkney

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12508 Chelton La., Bowie, MD 20715

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lincoln Cemetery

Date

Aug. 19, 00 Suitland, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Johnson & Jenkins Funeral Home  
716 Kennedy St., NW Washington, DC 20011

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Bilateral Subdural Hematoma

Approximate Interval Between Onset and Death

days

Due to (or as a consequence of):

b. Intracranial Bleed-with mid line shift

days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

LSRD

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 53411

29d. Date signed (Month, Day, Year)

Aug. 15, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3060 Mitchellville Rd., #103 Bowie, MD 20716

31. Date filed (Month, Day, Year)

AUG 16 2000

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27653

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARY J. LYONS

2. Date of Death

August 10, 2000

3. Time of Death

1414

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital Center

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

230-07-0645

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

DEC 2, 1918

9. Birthplace (State or Foreign Country)

NORTHAMPTON, VA

Usual Residence of Decedent

10a. State

VA

10b. County

NORTHAMPTON

10c. City, Town or Location

NASSAWADOX

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

P.O. BOX 332

10f. Zip Code

23413

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
8

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

DIETICIAN ASST.

16b. Kind of Business/Industry

PRIVATE

17. Father's Name (First, Middle, Last)

AISON UPSHUR

18. Mother's Name (First, Middle, Maiden Summa)

MARY BECKETT

19a. Informant's Name/Relationship (Type, Print)

DOROTHY LYONS WILSON / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3505 PARK WAY, CHEVERLY, MD 20785

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

SHORTERS CHAPEL AME CEMETERY 8-17-00 NASSAWADOX, VA

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Kath Sarge

22. Name and Address of Facility

ALEXANDER S. POPE FUNERAL HOME  
5538 MARLBORO PIKE, FORESTVILLE, MD 20747

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☒ Yes 2 ☐ NoHospital: 1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 8 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Salvador Sylvester, DO

29c. License number

H0055927

29d. Date signed (Month, Day, Year)

August 11, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Salvador Sylvester, 3001 Hospital Drive, Cheverly, Maryland 20785

31. Date filed (Month, Day, Year)

AUG 16 2000

32. Registrar's Signature

B. A. Smith

State  
Registrar

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27654

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RAYMOND FELTON LANEY				2. Date of Death Month Day Year August 10, 2000		3. Time of Death 1640 pm	
	4a. Facility Name (If not institution, give street and number) 1607 Nova Avenue				4b. City, Town, or Location of Death Capitol Heights		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 578 50 2433	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 62	8. Date of Birth (Month, Day, Year) Jan. 3, 1938	9. Birthplace (State or Foreign Country) Washington D.C.			
	Usual Residence of Decedent							
10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Capitol Heights		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 1607 Nova Avenue				10f. Zip Code 20743		10g. Citizen of What Country? USA		
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: UNKNOWN		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Management Specialist		16b. Kind of Business/Industry D.C. Government		
17. Father's Name (First, Middle, Last) John Laney				18. Mother's Name (First, Middle, Maiden Surname) Sadie Williams				
19a. Informant's Name/Relationship (Type, Print) John E. Laney, Jr. /brother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1607 Nova Avenue Capitol Heights, MD 20743				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		20c. Location - City or Town, State 8-14 Alexandria, Virginia				
21. Signature of Funeral Service Licensee <i>Emile C. Bruce-Tonic</i>				22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MD 4308 Suitland Road Suitland, MD 20746				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. <u>CONTACT GUNSHOT WOUND OF THE HEAD</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death								
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? PARTIAL 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) at scene				
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 8/10/00		28b. Time of Injury 1634 PM		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred SUBJECT SHOT SELF				28e. Location (Street and Number or Rural Route Number, City or Town, State) YARD IN FRONT OF RESIDENCE 1607 CAPITOL HTGS, NOVA AVE, MD				
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>John E. Laney, Jr., M.D.</i>				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) August 11, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARY G. RIPLEY, M.D. 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) AUG 14 2000				32. Registrar's Signature <i>Raymond F. Laney</i>				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

amend item 25 per phys G786 8/31/00 yr

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27655

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>James A. Lindell</b>				2. Date of Death Month Day Year <b>June 24 2000</b>		3. Time of Death <b>3:20 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>710 Americana Drive Apt. 55</b>				4b. City, Town, or Location of Death <b>Annapolis</b>		4c. County of Death <b>Anne Arundel</b>	
Funeral Director	5. Social Security Number <b>214-05-1831</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>83</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>January 31, 1917</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Annapolis</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>710 Americana Drive Apt. 55</b>		10f. Zip Code <b>21401</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Aeronautical Mechanic</b>		16b. Kind of Business/Industry <b>Aerospace</b>		17. Father's Name (First, Middle, Last) <b>Andrew Lindell</b>		
18. Mother's Name (First, Middle, Maiden Surname) <b>Alexandra Rombotis</b>		19a. Informant's Name/Relationship (Type, Print) <b>Jim Maley / stepson</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>215 Ambleside Drive Severna Park, MD 21146</b>		20e. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		
20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Ft. Lincoln Crematory</b>		20c. Location - City or Town, State <b>Brentwood, Maryland</b>		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Pancreas cancer</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		
28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Jeanine Werner, MD</b>		29c. License number <b>DS2830</b>		
29d. Date signed (Month, Day, Year) <b>June 26, 2000</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Jeanine Werner, 900 Bestgate Road, #300, Annapolis, MD 21401</b>		31. Date filed (Month, Day, Year) <b>JUN 27 2000</b>		32. Registrar's Signature 		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

DOUGLAS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27656

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

PATRICIA ANN MANESS

2. Date of Death

August 16 2000 3:40 PM

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Civista Medical Center

4b. City, Town, or Location of Death

LaPlata

4c. County of Death

Charles

Funeral  
Director

5. Social Security Number

579-52-5341

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

59

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Dec. 18, 1940

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Charles

10c. City, Town or Location

Welcome

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8655 Gunston Place

10f. Zip Code

20693

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (14 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Accountant

16b. Kind of Business/Industry

World Bank

17. Father's Name (First, Middle, Last)

Charles Herbert Ryan

18. Mother's Name (First, Middle, Maiden Surname)

Gladys Marie Langley

19a. Informant's Name/Relationship (Type, Print)

David V. Maness/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8655 Gunston Place, Welcome, Maryland 20695

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Ft. Lincoln Cemetery

Date

08-21-2000

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

MARK G. BROHAWN

22. Name and Address of Facility

The Hunt Funeral Home, Inc.

P.O. Box 156, Waldorf, Maryland 20604

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)a. *Cardio respiratory arrest*

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. *Severe Emphysema*

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Waheed Akhtar

29c. License number

D-31675

29d. Date signed (Month, Day, Year)

8-16-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Waheed U. Akhtar, M.D.

White Plains Medical Center  
P.O. Box 1737, White Plains, MD 20695State  
Registrar

31. Date filed (Month, Day, Year)

AUG 21 2000

32. Registrar's Signature

B. Sparks

ORIGINAL

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27657

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LAURA MATTINGLY MUDD</b>				2. Date of Death Month Day Year <b>August 20, 2000</b>				3. Time of Death <b>2:07 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Civista Medical Center</b>				4b. City, Town, or Location of Death <b>La Plata</b>				4c. County of Death <b>Charles</b>	
Funeral Director	5. Social Security Number <b>577-01-1492</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>85</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min	8. Date of Birth (Month, Day, Year) <b>July 15, 1915</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
	Usual Residence of Decedent									
10a. State <b>MD</b>		10b. County <b>Charles</b>		10c. City, Town or Location <b>Indian Head</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>1 Meekins Ave.</b>				10f. Zip Code <b>20640</b>		10g. Citizen of What Country? <b>USA</b>				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Postmaster</b>			16b. Kind of Business/Industry <b>Federal Govt.</b>			
17. Father's Name (First, Middle, Last) <b>William Joseph Mattingly</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Ellen Higdon</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Henry Mudd/Husband</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1 Meekins Ave. Indian Head, MD 20640</b>						
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Brinsfield-Echols Crem.</b>				Date <b>8/22/00</b>		20c. Location - City or Town, State <b>MD Charlotte Hall,</b>		
21. Signature of Funeral Service Licensee <b>David C Echols</b>		M 00945		22. Name and Address of Facility <b>AREHART-ECHOLS FUNERAL HOME, P.A. P.O. BOX 567 LA PLATA, MD. 20646</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Sepsis syndrome</b> Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Diabetes mellitus</b> <b>Myelofibrosis</b> Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier <b>B. Larry Jenkins, Jr.</b>				29c. License number <b>D-33426</b>		29d. Date signed (Month, Day, Year) <b>8/21/00</b>				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>B. Larry Jenkins, Jr. MD. 111 LaGrange Ave., LaPlata, Md. 20646</b>										
31. Date filed (Month, Day, Year) <b>AUG 22 2000</b>		32. Registrar's Signature <b>B. Sparks</b>								

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene

amend item 23a per phys. G786 8/31/00 yf

## Certificate of Death

Reg. No.

00 27658

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Mackenzie Lee McCulloch</b>				2. Date of Death Month Day Year <b>May 25, 2000</b>		3. Time of Death <b>6:11 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>18016 Cottage Garden Dr., Apt. 104</b>				4b. City, Town, or Location of Death <b>Germantown</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>220-55-1972</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. <b>7</b> Months <b>11</b>		8. Date of Birth (Month, Day, Year) <b>October, 14 1999</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Germantown</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>18016 Cottage Garden Drive Apt. 104</b>		10f. Zip Code <b>20874</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>0</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry				
17. Father's Name (First, Middle, Last) <b>Woodrow Lee McCulloch</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Jennifer Lynn Held</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Jennifer Lynn McCulloch/Mother</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>18016 Cottage Garden Drive, #104, Germantown, Md 20874</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Oakland Cemetery</b>		20c. Location - City or Town, State <b>May 28, 00 Indiana Pa.</b>				
21. Signature of Funeral Service Licensee <b>Olin L. Molesworth</b>				22. Name and Address of Facility <b>Olin L. Molesworth P.A. 26401 Ridge Road, Damascus, Md. 20872</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>CEREBROVASCULAR ACCIDENT</b> <b>Anoxic Brain Damage</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <b>Olin L. Molesworth</b>				29c. License number <b>D35635</b>		29d. Date signed (Month, Day, Year) <b>May 26, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Joseph Kaplan, M.D. 18111 Prince Philip Dr., Olney, Md. 20832</b>								
31. Date filed (Month, Day, Year) <b>MAY 31 2000</b>				32. Registrar's Signature <b>Blanca J. Sparks</b>				



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Amended Item 26, per Phy.

State of Maryland / Department of Health and Mental Hygiene

08/18/2000, Carroll County, wjl

## Certificate of Death

Reg. No.

00 27659

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Sean Christopher Cabaong Moyer				2. Date of Death Month Day Year August 16, 2000		3. Time of Death 6:52am		
	4a. Facility Name (If not institution, give street and number) 5725 Banjo Drive				4b. City, Town, or Location of Death Eldersburg		4c. County of Death Carroll		
Funeral Director	5. Social Security Number 215-25-8284		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 11 Yrs.		8. Date of Birth (Month, Day, Year) Apr 21, 1989		
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County Carroll		10c. City, Town or Location Eldersburg		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 5725 Banjo Drive		10f. Zip Code 21784		10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Student/ Athlete		16b. Kind of Business/Industry Elementary Ed/Athletics					
17. Father's Name (First, Middle, Last) Richard W. Moyer				18. Mother's Name (First, Middle, Maiden Surname) Marilyn Cabaong					
19a. Informant's Name/Relationship (Type, Print) (parents) Mr. & Mrs. Richard Moyer				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5725 Banjo Drive, Eldersburg, MD 21784					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Crestlawn Memorial Gardens		20c. Location - City or Town, State 8/21/00 Marriottsville, MD					
21. Signature of Funeral Service Licensee Brian A. Haight				22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Ependymoma Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death Four years							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Jeff Caley, MD		29c. License number D41444		29d. Date signed (Month, Day, Year) August, 17 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kenneth Cohen, M.D., Johns Hopkins Hospital, 600 North Wolfe Street, Baltimore						Maryland 21287-5001			
31. Date filed (Month, Day, Year) AUG 18 2000		32. Registrar's Signature Benita B Sparks							



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27660

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Alonzo McMullen

2. Date of Death  
Month Day Year  
August 14, 20003. Time of Death  
1745

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

290-26-4479

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

65 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Nov. 20, 1934

9. Birthplace (State or Foreign Country)

Youngstown, Ohio

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Bowie

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

16066 English Oaks Ave. Apt. C

10f. Zip Code

20716

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☐ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Clinic Manager

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Homer McMullen

18. Mother's Name (First, Middle, Maiden Surname)

Gladys Martin

19a. Informant's Name/Relationship (Type, Print)

Meade McMullen/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

16066 English Oaks Ave. Apt. C

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Cedar Hill Cemetery

Date

8/19/00

20c. Location - City or Town, State

Suitland, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Alexander S. Pope Funeral Homes

5538 Marlboro Pike/Forestville, Md.

20747

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Respiratory Failure

Due to (or as a consequence of):

b. Sepsis Secondary to Pneumonia

Due to (or as a consequence of):

c. Hypertensive Crises

Due to (or as a consequence of):

d. History of Hypertension, COPD

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No

25. Was case referred to medical

examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

MD D53691

29d. Date signed (Month, Day, Year)

August 15, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ajay Reddy M.D. 1500 Forest Glen Rd. Silver Spring, Md. 20910

State  
Registrar

31. Date filed (Month, Day, Year)

AUG 17 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,





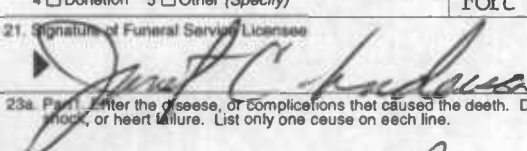
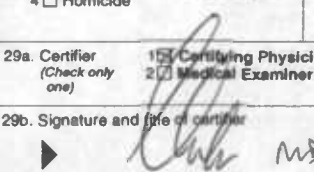

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

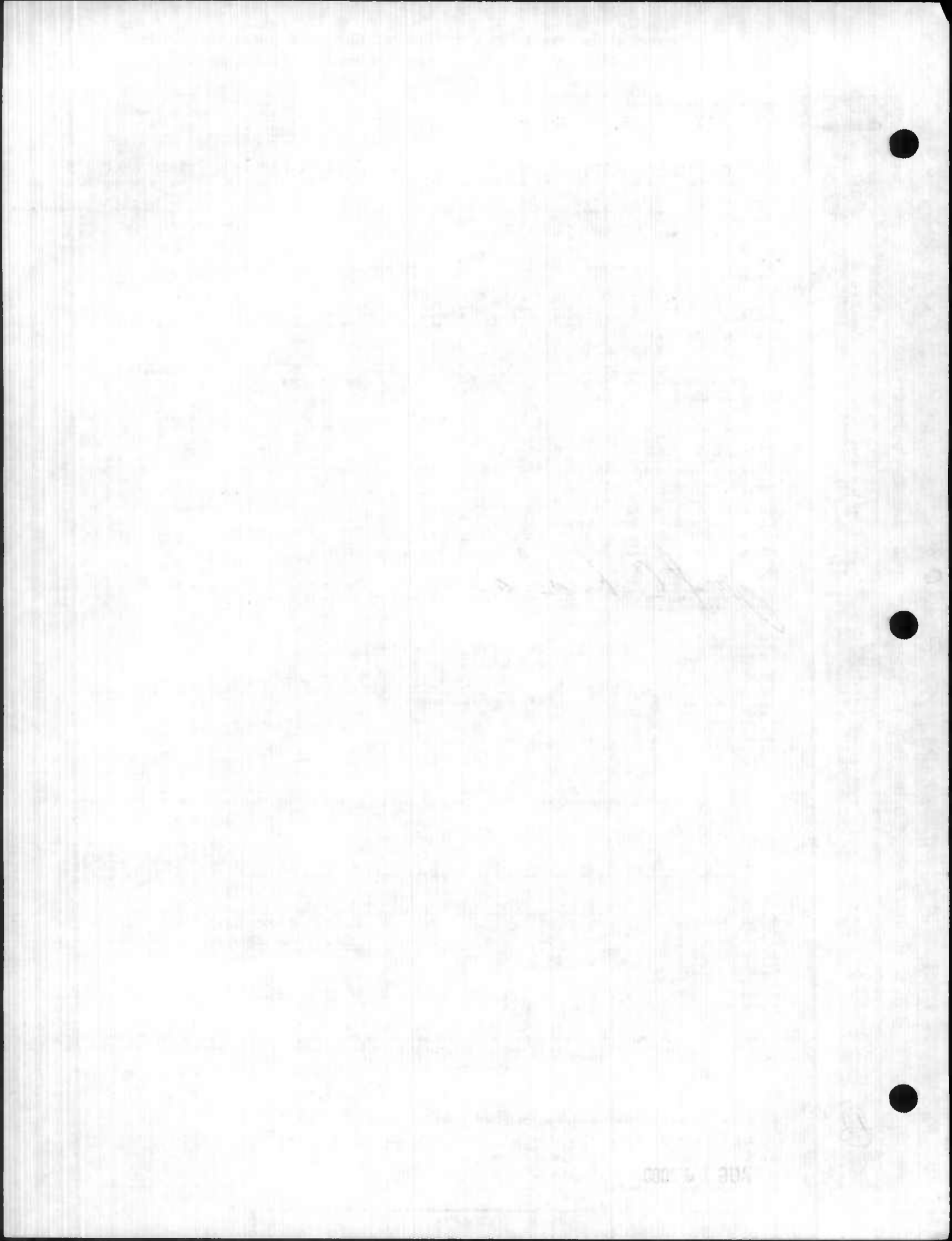
00 27661

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Clarzell O. Minor</b>		2. Date of Death Month <b>August</b> Day <b>9</b> Year <b>2000</b>		3. Time of Death <b>2034</b>
	4a. Facility Name (If not institution, give street and number) <b>Southern Maryland Hospital</b>		4b. City, Town, or Location of Death <b>Clinton, Maryland</b>		4c. County of Death <b>Prince George's Co.</b>
Funeral Director	5. Social Security Number <b>578-40-8575</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>65</b> Yrs.	If Under 1 Year Months <b>0</b> Days <b>0</b>	If Under 24 Hrs. Hours <b>0</b> Min. <b>0</b>
	8. Date of Birth (Month, Day, Year) <b>November 25, 1934</b>		9. Birthplace (State or Foreign Country) <b>Washington, D.C.</b>		
Usual Residence of Decedent					
10a. State <b>D.C.</b>		10b. County <b>Washington</b>		10c. City, Town or Location <b>Washington</b>	
10e. Street and Number <b>3228 D Street, S.E.</b>		10f. Zip Code <b>20019</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th Grade</b> College (1-4 or 5+) <b>College</b>			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>A.I.D.</b>		16b. Kind of Business/Industry <b>State Department</b>			
17. Father's Name (First, Middle, Last) <b>Alfred Minor</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Emma Mae Dozier</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Queen E. Minor (Wife)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3228 D Street, S.E. Washington, D.C. 20019</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Fort Lincoln Cemetery</b>		20c. Location - City or Town, State <b>08-14-2000 Brentwood, Maryland</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>ROLLINS FUNERAL HOME, INC. 4339 Hunt Place, N.E. Washington, D.C. 20019</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>PULMONARY EMBOLISM</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>CEREBROVASCULAR ACCIDENT</b> <b>HYPERTENSION</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			
28a. Date of Injury (Month, Day, Year) <b>28b. Time of Injury M</b> <b>28c. Injury at Work? 1 Yes 2 No</b>		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner		29b. Signature and title of certifier  MD			
29c. License number <b>DS3885</b>		29d. Date signed (Month, Day, Year) <b>8/10/2000</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>VENKAT. S. RAMANAM 7501 SURATTS ROAD #307 CLINTON MD 20735</b>					
31. Date filed (Month, Day, Year) <b>AUG 16 2000</b>		32. Registrar's Signature 			

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

00 27662

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Juanita M. Mathis				2. Date of Death Month: August Day: 11 Year: 2000				3. Time of Death 9:15PM	
	4a. Facility Name (If not institution, give street and number) Heartland Health Care				4b. City, Town, or Location of Death Hyattsville				4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 577-07-5716		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 90 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 19, 1910		9. Birthplace (State or Foreign Country) Wash., D.C.	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Upper Marlboro				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 13101 Water Fowl Way				10f. Zip Code 20774		10g. Citizen of What Country? United States			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: African American		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Statistical Clerk Mgr.			16b. Kind of Business/Industry Government		
	17. Father's Name (First, Middle, Last) Eugene Greenfield				18. Mother's Name (First, Middle, Maiden Surname) Roy Marie Pinkard					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Barbara S. Brown - Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13101 Water Fowl Way, Upper Marlboro, MD 20774					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Olivet Cemetery		Date 8/17/2000		20c. Location - City or Town, State Wash., D.C.			
	21. Signature of Funeral Service Licensee John T. Stewart, III				22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia Congestive Heart Failure									
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown									
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
State Registrar	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier Paul A. DeVore, MD				29c. License number D01852		29d. Date signed (Month, Day, Year) August 12 2000			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PAUL A. DEVORE MD 4203 Queensbury Rd Hyattsville MD 20781									
31. Date filed (Month, Day, Year) AUG 16 2000										
32. Registrar's Signature B. Sparks										

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Claude Irving McClain, Jr.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

amend item 23a per me G789 11/16/00 yf

## Certificate of Death

Reg. No.

00 27663

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Claude I. McClain, Jr.

2. Date of Death

August 09, 2000

3. Time of Death

4:40 pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

6810 Central Avenue, Apartment #403

4b. City, Town, or Location of Death

Capitol Heights

4c. County of Death

Prince George's

5. Social Security Number

577-68-4016

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

50

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

7/20/50

9. Birthplace (State or Foreign Country)

Wash., D.C.

Usual Residence of Decedent

10a. State

Md.

10b. County

P.G.

10c. City, Town or Location

Temple Hills

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

6003 St. Moritz Rd. # 202

10f. Zip Code

20748

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working

life. DO NOT use retired)

Warehouseman

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Claude I. McClain, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Elsie Lomax

19a. Informant's Name/Relationship (Type, Print)

Patricia Smith/Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2522 Senator Ave., District Hgts., Md. 20747

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Harmony Mem. Park

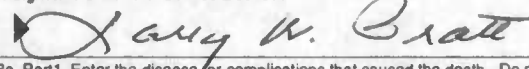
Date

8/17/00

20c. Location - City or Town, State

Landover, Md.

21. Signature of Funeral Service Licensee



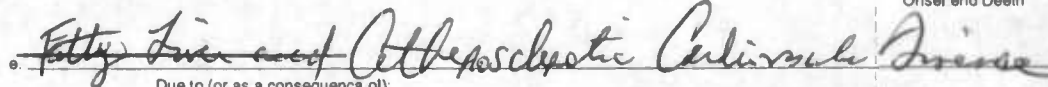
22. Name and Address of Facility

H.S. Washington &amp; Sons Co., Inc.

4925 Burroughs Ave., N.E., Wash., D.C. 20019

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)



Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

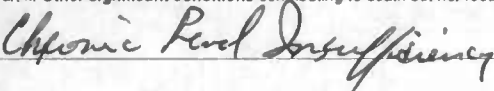
b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

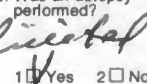
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.



23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) at scene

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier  
(Check only one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier



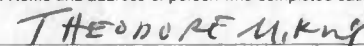
29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

August 10, 2000

30. Name and address of person who completed cause of death from 23a) (Type, Print)



111 Penn Street, Baltimore, Maryland 21201

State  
Registrar

31. Date filed (Month, Day, Year)

AUG 16 2000

32. Registrar's Signature



Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





00-4469-033

TERRY M. MARBURY

JVW

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27664

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Terry M. Marbury</b>				2. Date of Death Month Day Year <b>AUGUST 09, 2000</b>				3. Time of Death <b>11:09 P.M.</b>				
	4a. Facility Name (If not institution, give street and number) <b>6726 VERMONT COURT</b>				4b. City, Town, or Location of Death <b>LANDOVER</b>				4c. County of Death <b>PRINCE GEORGE'S</b>				
Funeral Director	5. Social Security Number <b>219-48-4975</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>34</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) <b>9-24-65</b>		
	9. Birthplace (State or Foreign Country) <b>Maryland</b>												
Usual Residence of Decedent													
10a. State <b>Md</b>			10b. County <b>PG</b>			10c. City, Town or Location <b>Landover</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
10e. Street and Number <b>6726 Vermont Court</b>						10f. Zip Code <b>20785</b>			10g. Citizen of What Country? <b>USA</b>				
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>No</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4or 5+)						16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Truck Driver</b>			16b. Kind of Business/Industry <b>Pvt</b>				
17. Father's Name (First, Middle, Last) <b>Carl Carter</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Patrica Marbury</b>							
19a. Informant's Name/Relationship (Type, Print) <b>Patrica Woodland</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Same as #10</b>							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Fort Lincoln Cemetery</b>			Date <b>8-17-00</b>			20c. Location - City or Town, State <b>Blandensbury Md</b>				
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility <b>Snead Funeral Home</b> <b>5732 Georgia Ave. N.W. Washington, DC</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Contact gunshot wound of head</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last													
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown													
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No													
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No													
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No													
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b>													
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year) <b>8-9-2000</b>			28b. Time of Injury <b>Found 2300 M</b>			28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			28d. Describe how injury occurred <b>Subject shot self</b>	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Residence</b>						28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>6726 Vermont Court Prince Georges County, Maryland</b>							
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
29b. Signature and title of certifier  <b>Stephen S. Radentz, M.D.</b>						29c. License number <b>O.C.M.E.</b>			29d. Date signed (Month, Day, Year) <b>AUGUST 10, 2000</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201</b>													
31. Date filed (Month, Day, Year) <b>AUG 16 2000</b>						32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Important: If item 27 is marked other than "natural", or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27665

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Harry William McMurdy</b>				2. Date of Death Month Day Year <b>August 10, 2000</b>		3. Time of Death <b>10:20 am</b>		
	4a. Facility Name (If not institution, give street and number) <b>North Arundel Hospital</b>				4b. City, Town, or Location of Death <b>Glen Burnie</b>		4c. County of Death <b>Anne Arundel</b>		
Funeral Director	5. Social Security Number <b>170-32-0383</b>	6. Sex <b>2</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (in yrs. last birthday) <b>60</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>May 21, 1940</b>		9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Bowie</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>12305 Thompson Road</b>				10f. Zip Code <b>20720</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Communications Engineer</b>			16b. Kind of Business/Industry <b>NASA Goddard Space Flight Center</b>			
	17. Father's Name (First, Middle, Last) <b>Gaylord Allen McMurdy</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Sarah Hannah Jones</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Natalie P. McMurdy - Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12305 Thompson Road, Bowie, MD 20720</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Washington Cemetery</b>		Date <b>8/15/00</b>		20c. Location - City or Town, State <b>Washington, PA</b>		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Metastatic Adenocarcinoma of the Esophagus</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes Mellitus</b>								
Physician /Medical Examiner	23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Rakesh Arora, MD</b>		29c. License number <b>D20108</b>		29d. Date signed (Month, Day, Year) <b>8/10/00</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>RAKESH ARORA, MD 14300 GALLANT FOX LN #222, BOWIE, MD 20715</b>									
31. Date filed (Month, Day, Year) <b>AUG 14 2000</b>				32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27666

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Gloria Schuster Mooers

2. Date of Death

August 17 2000

3. Time of Death

1020

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

220-16-2958

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 2, 1923

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

901 Queen Anne's Ct.

10f. Zip Code

21740

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Paralegal

16b. Kind of Business/Industry

Law Firm

17. Father's Name (First, Middle, Last)

James Schuster

18. Mother's Name (First, Middle, Maiden Surname)

Madeleine Dryer

19a. Informant's Name/Relationship (Type, Print)

Richard C. Mooers (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

901 Queen Anne's Ct. Hagerstown, Md. 21740

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Smithsburg Crematory

Date

Aug. 18, 2000

20c. Location - City or Town, State

Smithsburg, Md.

21. Signature of Funeral Service Licensee

Dennis L. Davis

22. Name and Address of Facility

12525 Bradbury Ave. Davis Funeral Home Smithsburg, Md. 21783

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

b. Chronic Obstructive Pulmonary Disease years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dennis L. Davis

29c. License number

D21457

29d. Date signed (Month, Day, Year)

8-17-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ABDUL WATERS MD - 12821 - OAK HILL AVE HAGERSTOWN, MD

31. Date filed (Month, Day, Year)

AUG 18 2000

32. Registrar's Signature

Dennis L. Davis

State  
Registrar

ORIGINAL

Mooers, Gloria Schuster

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27667

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Ethel Louise MONGAN</b>				2. Date of Death Month Day Year <b>AUGUST 20 2000</b>		3. Time of Death <b>0542</b>
	4a. Facility Name (If not institution, give street and number) <b>WASHINGTON COUNTY HOSPITAL</b>				4b. City, Town, or Location of Death <b>HAGERSTOWN</b>		4c. County of Death <b>WASHINGTON</b>
Funeral Director	5. Social Security Number <b>218-40-3537</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>59</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>OCT. 19, 1940</b>	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>
	Usual Residence of Decedent						
10a. State <b>MARYLAND</b>		10b. County <b>WASHINGTON</b>		10c. City, Town or Location <b>HAGERSTOWN</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>261 SOUTH POTOMAC STREET</b>				10f. Zip Code <b>21740</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> Collega (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>ATTENDANT</b>		16b. Kind of Business/Industry <b>CAR WASH</b>	
17. Father's Name (First, Middle, Last) <b>CLYDE MILTON MONGAN</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>ELIZABETH ALVERTA STULL</b>			
19a. Informant's Name/Relationship (Type, Print) <b>JUDY M. RAMIREZ/DAUGHTER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>261 SOUTH POTOMAC STREET, HAGERSTOWN, MARYLAND 21740</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MANOR CEMETERY</b>		Data <b>8/24/00</b>		20c. Location - City or Town, State <b>BOONSBORO, MARYLAND</b>	
21. Signature of Funeral Service Licensee  Paul M. Dean				22. Name and Address of Facility <b>BAST FUNERAL HOME</b> <b>7606 Old National Pike</b> <b>Boonsboro, Maryland 21713</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. Bacterial Septicemia</b> Dua to (or as a consequence of): <b>b. Cancer metastatic to Bladder</b> Dua to (or as a consequence of): <b>c.</b> Dua to (or as a consequence of): <b>d.</b> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death <b>24hr</b> <b>1 year</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Pancreatitis, Acute Renal failure</b> <b>Hepatitis</b> <b>Chronic Alcoholism</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 				29c. License number <b>035547</b>		29d. Date signed (Month, Day, Year) <b>August 20 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Stephen S. Lippman, M.D. 11110 MedicalCampusRoad, Hagerstown, MD 21742</b>							
31. Date filed (Month, Day, Year) <b>AUG 22 2000</b>		32. Registrar's Signature 					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

MONGAN, Ethel Louise



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27668

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>SOPHIE MARIE MINJOCK</b>				2. Date of Death Month Day Year <b>August 21, 2000</b>		3. Time of Death <b>0925</b>	
	4a. Facility Name (If not institution, give street and number) <b>20134 Teakwood Drive</b>				4b. City, Town, or Location of Death <b>Hagerstown</b>		4c. County of Death <b>Washington</b>	
Funeral Director	5. Social Security Number <b>209-05-9836</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>85</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>July 1, 1915</b>	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>
	Usual Residence of Decedent							
10a. State <b>Pa.</b>		10b. County <b>Allegheny</b>		10c. City, Town or Location <b>Monongahela</b>			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number <b>3417 Rainbow Run Road</b>				10f. Zip Code <b>15063</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+)				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>		
17. Father's Name (First, Middle, Last) <b>John Grcich</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Gawansky</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Patricia A. Toth</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7416 Hawkins Drive, Hanover, Maryland 21076</b>				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Round Hill Cemetery</b>		Date <b>08-23-2000</b>		20c. Location - City or Town, State <b>Elizabeth, Pa.</b>	
21. Signature of Funeral Service Licensee <b>R. Noel Brady</b>				22. Name and Address of Facility <b>Andrew K. Coffman Funeral Home, Inc. 40 East Antietam Street, Hagerstown, Md. 21740</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Carcinoma of Bladder</b>								Approximate Interval Between Onset and Death <b>7 months</b>
Due to (or as a consequence of):								
Due to (or as a consequence of):								
Due to (or as a consequence of):								
Due to (or as a consequence of):								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>Granddaughters residence</b>				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <b>Frederic H. Kass III M.D.</b>				29c. License number <b>D23623</b>		29d. Date signed (Month, Day, Year) <b>August 21, 2000</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Frederic H. Kass III M.D. 11110 Medical Campus Road, Hagerstown, Md. 21740</b>								
31. Date filed (Month, Day, Year) <b>AUG 23 2000</b>				32. Registrar's Signature <b>Benjamin Sparks</b>				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27669

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ROUMEN NENTCHEV</b>				2. Date of Death Month <b>August</b> Day <b>13</b> Year <b>2000</b>		3. Time of Death <b>17:30</b>	
	4a. Facility Name (If not institution, give street and number) <b>SHADY GROVE ADVENTIST HOSPITAL</b>				4b. City, Town, or Location of Death <b>ROCKVILLE</b>		4c. County of Death <b>MONTGOMERY</b>	
Funeral Director	5. Social Security Number <b>066-82-5119</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (in yrs. last birthday) <b>60</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>June 21, 1940</b>		9. Birthplace (State or Foreign Country) <b>Bulgaria</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Silver Spring</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>2715 University Blvd.</b>				10f. Zip Code <b>20902</b>		10g. Citizen of What Country? <b>Bulgaria</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Bulgaria</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>2 1/2</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Sale Clerk</b>			16b. Kind of Business/Industry <b>Private</b>	
17. Father's Name (First, Middle, Last) <b>Nentcho Nentchev</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Rozka Ilieva</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Sylvia Rolinski - Attorney</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>14915 River Road, Potomac, MD 20854</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Lee's Crematory</b>		Date <b>8/21/2000</b>		20c. Location - City or Town, State <b>Clinton, MD</b>
21. Signature of Funeral Service Licensee <b>John T. Stewart, III</b>				22. Name and Address of Facility <b>Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. ANTERIOR MYOCARDIAL INFARCTION</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <b>M.D. (OMB)</b>				29c. License number <b>015236</b>		29d. Date signed (Month, Day, Year) <b>AUGUST 13, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>CARL E. MARGOLIS, MD 11125 ROCKVILLE PIKE, ROCKVILLE, MD 20854</b>								
31. Date filed (Month, Day, Year) <b>AUG 17 2000</b>				32. Registrar's Signature <b>B. Smith</b>				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27670

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Julian Lawrence Owen</b>				2. Date of Death Month Day Year <b>August 20, 2000</b>		3. Time of Death <b>8:45 p.m.</b>		
	4a. Facility Name (If not institution, give street and number) <b>102 Beecher Avenue</b>				4b. City, Town, or Location of Death <b>Indian Head</b>		4c. County of Death <b>Charles</b>		
Funeral Director	5. Social Security Number <b>213-01-8949</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>80</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>10-14-1919</b>		
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10. Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Charles</b>		10c. City, Town or Location <b>Indian Head</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number <b>102 Beecher Avenue</b>				10f. Zip Code <b>20640</b>		10g. Citizen of What Country? <b>United States</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>1942</b> If Yes, Give Year or Dates: <b>1956</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+)		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Engineering Technician</b>		16b. Kind of Business/Industry <b>U.S. Government</b>				
	17. Father's Name (First, Middle, Last) <b>Julian Clarence Owen</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Agnes Louise Adams</b>				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>John M. Owen/Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4614 Rincon Place, Dumfries, Virginia 22026</b>				
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metropolitan Crematory</b>		Date <b>August 22, 2000</b>		20c. Location - City or Town, State <b>Alexandria, Virginia</b>		
	21. Signature of Funeral Service Licensee  <b>M00668</b>		22. Name and Address of Facility <b>Williams Funeral Home, P.A. 20640</b> <b>4270 Hawthorne Road, Indian Head, Maryland</b>						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>e. Coronary Artery Disease</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>D0050883</b>		29d. Date signed (Month, Day, Year) <b>August 21, 2000</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Yahia M. Tagouri, M.D. P.O. Box 527, 25500 Point Lookout Road</b>		Leonardtwn, Maryland 20650							
31. Date filed (Month, Day, Year) <b>AUG 22 2000</b>		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27671

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Barbara Ann Oliver</b>				2. Date of Death Month <b>August</b> Day <b>19</b> Year <b>2000</b>		3. Time of Death <b>09:12A</b>		
	4a. Facility Name (If not institution, give street and number) <b>1061 Union Church Road</b>				4b. City, Town, or Location of Death <b>Elkton</b>		4c. County of Death <b>Cecil</b>		
Funeral Director	5. Social Security Number <b>221-54-5788</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (in yrs. last birthday) <b>42</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>June 17, 1958</b>		
	9. Birthplace (State or Foreign Country) <b>Delaware</b>		10a. State <b>Maryland</b>		10b. County <b>Cecil</b>		10c. City, Town or Location <b>Elkton</b>		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>1061 Union Church Road</b>		10f. Zip Code <b>21921</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>In Her Own Home</b>		17. Father's Name (First, Middle, Last) <b>William J. Hammons</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Christine M. Cordrey</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Christine M. Goodyear/Mother</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>110 Kirk Road, Elkton, Maryland 21921</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Leeds Cemetery</b>		20c. Location - City or Town, State <b>8/23/00 Leeds, Maryland</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Hicks Home for Funerals, P.A. 103 W. Stockton St., Elkton, Maryland 21921</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>Myocardial Infarction</b> Due to (or as a consequence of): b. <b>Diabetes Mellitus</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown  24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		Approximate Interval Between Onset and Death <b>immed.</b> <b>years</b>			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>00053309</b>		29d. Date signed (Month, Day, Year) <b>August 19, 2000</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Jeffrey Flanagan MD 300 Bow St Elkton MD 21921</b>		31. Date filed (Month, Day, Year) <b>AUG 21 2000</b>		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27672

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Arlene Renee Porter			2. Date of Death Month Day Year August 13, 2000		3. Time of Death 2350	
	4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital			4b. City, Town, or Location of Death Clinton		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 232-72-3620	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 53	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month Day Year Oct. 10, 1946	9. Birthplace (State or Foreign Country) West Virginia
	Usual Residence of Decedent						
10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Upper Marlboro		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 17240 Brookmeadow Lane			10f. Zip Code 20772		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 1			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cosmetologist		16b. Kind of Business/Industry Personal Care		
17. Father's Name (First, Middle, Last) Adrien Pauley				18. Mother's Name (First, Middle, Maiden Surname) Lubechem Ball			
19a. Informant's Name/Relationship (Type, Print) Wilson Porter (Husband)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17240 Brookmeadow Lane Upper Marlboro MD 20772			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lee Crematory		Date August 15, 2000		20c. Location - City or Town, State Clinton, Maryland	
21. Signature of Funeral Service Licensee [Signature]				22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD 20735			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cancer Cervix Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes mellitus							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)			
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier [Signature] MD - Physician				29c. License number 002259		29d. Date signed (Month, Day, Year) Aug 14, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rene G. [Signature] Clinton, MD 20735							
31. Date filed (Month, Day, Year) AUG 16 2000		32. Registrar's Signature [Signature]					

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27673

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

James A. Pfaff

2. Date of Death

Month Day Year  
August 12, 2000

3. Time of Death

11:38AM

4a. Facility Name (If not institution, give street and number)

6305 Middleton Ln.

4b. City, Town, or Location of Death

Camp Springs

4c. County of Death

Prince Georges

Funeral  
Director

5. Social Security Number

215-18-3020

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

79

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
March 7, 1921

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George

10c. City, Town or Location

Camp Spring

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6305 Middleton Ln.

10f. Zip Code

20748

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1944-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working

life. DO NOT use retired)

Physical Science Technician

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Philipp Pfaff

18. Mother's Name (First, Middle, Maiden Surname)

Anna Mattern

19a. Informant's Name/Relationship (Type, Print)

Juanita H. Pfaff (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6305 Middleton Lane Camp Springs, Maryland 20748

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

August 16, 2000  
Maryland State Veterans Cem.

Date

20c. Location - City or Town, State

Cheltenham, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Lee Funeral Home, Inc.

6633 Old Alexandria Ferry Road Clinton, MD 20735

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Carcinomatosis

Due to (or as a consequence of):

b. Hepatic Metastases

Due to (or as a consequence of):

c. Carcinoma of Distal Bile Duct and Periapulla

Due to (or as a consequence of):

d.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Heart Disease

Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy

performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings

available prior to

completion of cause

of death?

N/A

1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural  
2 ☐ Accident  
3 ☐ Suicide  
4 ☐ Homicide5 ☐ Pending  
Investigation  
6 ☐ Could not be  
determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

M

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29e. Certifier  
(Check only  
one)29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D0020678

29d. Date signed (Month, Day, Year)

August 14, 2000

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

Edwarda Buda, M.D. 3904 Cleveland St. Kensington, Md.

31. Date filed (Month, Day, Year)

AUG 15 2000

32. Registrar's Signature

State  
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

perml. Pages 1 and 2 should be filled within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
5050.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27674

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Anna M. Parana

2. Date of Death

August 11, 2000

3. Time of Death

4:00 pm

4a. Facility Name (If not institution, give street and number)

Magnolia Gardens Nursing Home

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

187-40-6978

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

95

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 7, 1905

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Lanham

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

8200 Good Luck Road

10f. Zip Code

20706

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Joseph Parana

18. Mother's Name (First, Middle, Maiden Surname)

Mary Spillar

19a. Informant's Name/Relationship (Type, Print)

Helen Falten - Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4215 75th Avenue, Hyattsville, Maryland 20784

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holy Family Cemetery

Date

8/18/2000

20c. Location - City or Town, State

Throop, Pennsylvania

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Gasch's Funeral Home, P.A.  
4739 Baltimore Ave., Hyattsville, MD 20781

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

b. Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D0026823

29d. Date signed (Month, Day, Year)

August 14, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Katherine Sanzaro, M.D., 5804 Baltimore Avenue, Hyattsville, MD 20781

31. Date filed (Month, Day, Year)

AUG 14 2000

32. Registrar's Signature

B. B. B.

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27675

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JAMES R. PROCTOR JR.</b>				2. Date of Death Month: <b>8</b> Day: <b>9</b> Year: <b>2000</b>		3. Time of Death <b>9:30pm.</b>	
	4a. Facility Name (If not institution, give street and number) <b>WASHINGTON ADVENTIST HOSPITAL</b>				4b. City, Town, or Location of Death <b>TAKOMA PARK</b>		4c. County of Death <b>MONTGOMERY</b>	
Funeral Director	5. Social Security Number <b>579-68-0272</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>49</b> Yrs.	If Under 1 Year Months: Days:	If Under 24 Hrs. Hours: Min.	8. Date of Birth (Month, Day, Year) <b>9-11-1950</b>		9. Birthplace (State or Foreign Country) <b>WASHINGTON D.C.</b>
	Usual Residence of Decedent							
10a. State <b>MD.</b>		10b. County <b>PRINCE GEORGES</b>		10c. City, Town or Location <b>HYATTSVILLE</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10a. Street and Number <b>4209 oglethrope St. Apt#3</b>				10f. Zip Code <b>20781</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary (Secondary (9-12)) <b>10th</b> Collega (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>CUSTODIAL</b>		16b. Kind of Business/Industry <b>CHURCH</b> <b>19th St. Baptist</b>		
17. Father's Name (First, Middle, Last) <b>JAMES R. PROCTOR SR.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>BARBRA PROCTOR</b>				
19a. Informant's Name/Relationship (Type, Print) <b>BARBRA P. CARTER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3102 BANNKER DR. WASHINGTON, D.C. 20018</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Riverdale Crematory</b>		20c. Location - City or Town, State <b>8-14-2000 Riverdale Md.</b>		
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>TYRONE J. YOUNG 719 Kennedy ST. N.W.</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Respiratory failure - Acute</b> Due to (or as a consequence of): <b>b. Cancer Lung</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Approximate Interval Between Onset and Death <b>2-3 days</b> <b>months/years</b>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i> MD		29c. License number <b>D 53411</b>		29d. Date signed (Month, Day, Year) <b>August 11<sup>th</sup> 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ( <i>Dr. J. Shesadri</i> ) <b>BTMP, 3060 mitchellville Rd # 103 Bowie MD 20716</b>								
31. Date filed (Month, Day, Year) <b>AUG 14 2000</b>		32. Registrar's Signature <i>[Signature]</i>						

ORIGINAL

Handwritten signature or mark



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27676

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) William R. Rankin		2. Date of Death Month <u>August</u> Day <u>13</u> Year <u>2000</u>		3. Time of Death <u>2:20pm</u>
	4a. Facility Name (If not institution, give street and number) Doctor's Community Hospital		4b. City, Town, or Location of Death Lanham		4c. County of Death Prince George's
Funeral Director	5. Social Security Number 578-01-0023	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) Sept. 9, 1913		9. Birthplace (State or Foreign Country) Pennsylvania		
Usual Residence of Decedent					
10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Hyattsville	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number 4110 Queensbury Road		10f. Zip Code 20781		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <u>White</u>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>10</u> College (1-4 or 5+) <u>-</u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Building Engineer		16b. Kind of Business/Industry US Chamber of Commerce	
17. Father's Name (First, Middle, Last) Alva C. Rankin		18. Mother's Name (First, Middle, Maiden Surname) Rose Bryson			
19a. Informant's Name/Relationship (Type, Print) Violet Rankin - Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4110 Queensbury Road, Hyattsville, MD 20781			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Laurel Hill Cemetery		20c. Location - City or Town, State 8/17/00 Dunbar Township, PA	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		a. <u>Respiratory Failure</u> Due to (or as a consequence of):		11 days	
		b. <u>Pneumonia</u> Due to (or as a consequence of):		11 days	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		c. <u>Non-small cell Carcinoma Lung</u> Due to (or as a consequence of):		10 months	
		d.			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Hypertensive Heart Disease</u>					
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number D 22549		29d. Date signed (Month, Day, Year) August 14, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) G. M. Dind, M.D. 6510 Kenilworth Ave., Riverdale M.D. 20737					
31. Date filed (Month, Day, Year) AUG 16 2000		32. Registrar's Signature 			

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27677

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Irma Marden Rosenberry</b>				2. Date of Death Month Day Year <b>August 14 2000</b>		3. Time of Death <b>1037</b>	
	4a. Facility Name (If not institution, give street and number) <b>The Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Easton</b>		4c. County of Death <b>Talbot</b>	
Funeral Director	5. Social Security Number <b>212-34-6300</b>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>81</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	6. Date of Birth (Month, Day, Year) <b>Apr. 21, 1919</b>		9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Queen Anne</b>		10c. City, Town or Location <b>Grasonville</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>4805 Main St.</b>				10f. Zip Code <b>21638</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No, if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+) <b></b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Housewife</b>		16b. Kind of Business/Industry <b>Home</b>		
17. Father's Name (First, Middle, Last) <b>George Washington Craig</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Myrtle Shirk</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Janet L. Purdham/Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4805 Main St. Grasonville, Maryland 21638</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cedar Lawn Memorial Park</b>		Date <b>8-18-00</b>		20c. Location - City or Town, State <b>Hagerstown, Maryland</b>		
21. Signature of Medical Service Licensee 				22. Name and Address of Facility <b>Osborne Funeral Home, P.A. 425 S. Conococheague St. Williamsport, MD 21795</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Sepsis (? underlying pneumonia) ~ 30 hrs</b> Due to (or as a consequence of): <b>b. myocardial ischemia - non Q-wave MI</b> Due to (or as a consequence of): <b>c. acute renal failure</b> Due to (or as a consequence of): <b>d.</b>  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>H55274</b>		29d. Date signed (Month, Day, Year) <b>8/14/00</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Jeaninne Einfalt, M.D. 219 S. Washington St. Easton, MD 21601</b>								
31. Date filed (Month, Day, Year) <b>AUG 17 2000</b>		32. Registrar's Signature 						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



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State of Maryland / Department of Health and Mental Hygiene

00 27678

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Virginia NMN RHOADES				2. Date of Death Month Day Year Aug 16, 2000		3. Time of Death 3:14 PM	
	4a. Facility Name (If not institution, give street and number) Western Maryland Hospital Center				4b. City, Town, or Location of Death Hagerstown		4c. County of Death Washington	
Funeral Director	5. Social Security Number 211-26-2832		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 64 Yrs.		8. Date of Birth (Month, Day, Year) August 13, 1936	
	9. Birthplace (State or Foreign Country) Pennsylvania		10a. State Pennsylvania		10b. County York		10c. City, Town or Location York	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 942 Marbrooke Lane		10f. Zip Code 17404		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (14 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) homemaker		16b. Kind of Business/Industry her own home			
	17. Father's Name (First, Middle, Last) Jessie James Martin				18. Mother's Name (First, Middle, Maiden Surname) Mary O. Hunter			
	19a. Informant's Name/Relationship (Type, Print) Jason Rhoades - son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 942 Marbrooke Lane, York, Pa. 17404			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lebanon Cemetery		Date 8-19-00		20c. Location - City or Town, State York, Pennsylvania	
	21. Signature of Funeral Service Licensee <i>Scott M. Munnich</i>				22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. Acute Respiratory Failure Due to (or as a consequence of): minutes b. Advanced Amyotrophic Lateral Sclerosis Due to (or as a consequence of): years c. Due to (or as a consequence of): d.							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
Medical Certification: To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier <i>Rose Marie Chan, M.D.</i>				29c. License number D 76416		29d. Date signed (Month, Day, Year) Aug. 16, 2000	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROSE MARIE CHAN, M.D. 1500 Pennsylvania Avenue Hagerstown, MD 21742							
State Registrar	31. Date filed (Month, Day, Year) AUG 17 2000		32. Registrar's Signature <i>Sparks</i>					







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State of Maryland / Department of Health and Mental Hygiene

00 27679

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary Sloan Watson Romine				2. Date of Death Month Day Year June 25, 2000				3. Time of Death 0025hrs	
	4a. Facility Name (If not institution, give street and number) Kent & Queen Anne's Hospital				4b. City, Town, or Location of Death Chestertown				4c. County of Death Kent	
Funeral Director	5. Social Security Number 221-18-8962		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 71 Yrs.		8. Date of Birth (Month, Day, Year) July 5, 1928		9. Birthplace (State or Foreign Country) Baltimore, MD	
	Usual Residence of Decedent				10a. State Maryland		10b. County Kent		10c. City, Town or Location Chestertown	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				10e. Street and Number 208 David Drive		10f. Zip Code 21620		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Own home	
	17. Father's Name (First, Middle, Last) John Graham Watson				18. Mother's Name (First, Middle, Maiden Surname) Mary Sloan Roberts					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Carol Annette Romine/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 201 Valley Road, Chestertown, Maryland 21620					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Cremation Center, LLC 6/26/2000 Stevensville, Maryland		20c. Location - City or Town, State					
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Fellows, Helfenbein & Newman Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Multi-Organ Failure Due to (or as a consequence of): b. Congestive Heart Failure Due to (or as a consequence of): c. Ex Left hip Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death 36 hours 3 days 1 week					
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
					24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) 6/20		28b. Time of Injury 0001 M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred TXIP in BATHROOM	
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Bathroom of Residence				28f. Location (Street and Number or Rural Route Number, City or Town, State) 208-DAVID DRIVE CHESTERTOWN					
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 				29c. License number D36054	
To Be Completed by Physician/Medical Examiner	29d. Date signed (Month, Day, Year) 6/27				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PATRICIA J SHAWM 120 SPEER RD CHESTERTOWN					
	31. Date filed (Month, Day, Year) JUN 27 2000				32. Registrar's Signature 					



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State of Maryland / Department of Health and Mental Hygiene

00 27680

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Anne B. Roberts

2. Date of Death  
Month Day Year  
AUGUST 7, 20003. Time of Death  
3:22 P.M.

4a. Facility Name (If not institution, give street and number)

Berlin Nursing and Rehabilitation Ctr.

4b. City, Town, or Location of Death

Berlin

4c. County of Death

Worcester

Funeral  
Director

5. Social Security Number

207-16-3013

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 6, 1926

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

Worcester

10c. City, Town or Location

Berlin

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

9715 Healthway Drive

10f. Zip Code

21811

10g. Citizen of What Country?

US

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1 ☐ Yes 2 ☒ No

Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Joseph Bolitsky

18. Mother's Name (First, Middle, Maiden Surname)

Diana Suback

19a. Informant's Name/Relationship (Type, Print)

John P. Roberts

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

RR2 Box 44, Selbyville, Delaware 19975

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Sunset Memorial Park

Date

Aug. 10

20c. Location - City or Town, State

Berlin, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

The Burbage Funeral Home

108 William St., Berlin, Md. 21811

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line.

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Emphysema

Due to (or as a consequence of):

c. Smoking

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

1 week

2 yr

3 yr

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Anxiety

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D02026

29d. Date signed (Month, Day, Year)

Aug 4 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Federico G. Arthes, M.D. 9715 Healthway Dr., Berlin, Md. 21811

State  
Registrar

31. Date filed (Month, Day, Year)

AUG 10 2000

32. Registrar's Signature

[Signature]

ORIGINAL

ROBERTS, ANNE H

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760, BALTIMORE, MD 21268-0760



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27681

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) James N. Sample, Sr.				2. Date of Death Month Day Year August 16 2000		3. Time of Death 2103	
	4a. Facility Name (If not institution, give street and number) Union Hospital				4b. City, Town, or Location of Death Elkton		4c. County of Death Cecil.	
Funeral Director	5. Social Security Number 216-01-8022	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) OCT 3, 1916		9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland	10b. County Cecil.	10c. City, Town or Location Elkton			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	10e. Street and Number 336 West Main Street				10f. Zip Code 21921		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1945		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 10		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Owner/Operator		16b. Kind of Business/Industry Grocery Store			
	17. Father's Name (First, Middle, Last) Joseph Andrew Sample				18. Mother's Name (First, Middle, Maiden Surname) Edna May McCall			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Barbara L. Mullins/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 317 West Main Street, Elkton, Maryland 21921			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Bethel Cemetery		Date 8/20/00		20c. Location - City or Town, State Chesapeake City, MD	
	21. Signature of Funeral Service Licensee Donald S. Hicks				22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton St., Elkton, MD 21921			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Myocardial Infarction Due to (or as a consequence of): b. Coronary Artery Disease Due to (or as a consequence of): c. Chronic Obstructive Pulmonary Disease Due to (or as a consequence of): d. Non Insulin Dependant Diabetes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death Hours Years Years Years			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred			
					28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier MD		29c. License number 00047711		29d. Date signed (Month, Day, Year) AUGUST 18, 2000	
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID GAR-EL 3 MAULDIN AVENUE NORTH EAST MARYLAND 21901							
	31. Date filed (Month, Day, Year) AUG 21 2000				32. Registrar's Signature B. Sparks			

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended Item #1 per Phy.

State of Maryland / Department of Health and Mental Hygiene

00 27682

08/18/2000, Carroll County, wjl

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>RAYMOND HARRY SILKWORTH, SR.</b>				2. Date of Death Month <b>08</b> Day <b>14</b> Year <b>2000</b>		3. Time of Death <b>1815</b>	
	4a. Facility Name (If not institution, give street and number) <b>Carroll County General Hospital</b>				4b. City, Town, or Location of Death <b>Westminster MD</b>		4c. County of Death <b>Carroll</b>	
Funeral Director	5. Social Security Number <b>214-16-6209</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>97</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>9/23/1902</b>	9. Birthplace (State or Foreign Country) <b>PENNSYLVANIA</b>
	Usual Residence of Decedent							
10a. State <b>MD.</b>		10b. County <b>CARROLL</b>		10c. City, Town or Location <b>WESTMINSTER</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>205 ST. MARK WAY</b>				10f. Zip Code <b>21158</b>		10g. Citizen of What Country? <b>USA.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+) <b></b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>MECHANIC</b>			16b. Kind of Business/Industry <b>STATE GOVERNMENT</b>	
17. Father's Name (First, Middle, Last) <b>ISRAEL SILKWORTH</b>				18. Mother's Name (First, Middle, Maiden Summa) <b>NELLIE PORTER</b>				
19a. Informant's Name/Relationship (Type, Print) <b>SON</b> <b>RAYMOND H. SILKWORTH, JR.</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5040 DRY RUN RD., HEDGESVILLE, W.VA. 25427</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>EVERGREEN MEM. GARDENS</b>		20c. Location - City or Town, State <b>8/17/00 FINKSBURG, MD.</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>FLETCHER FUNERAL HOME</b> <b>254 E. MAIN ST., WESTMINSTER, MD. 21157</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or habit failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Hypovolemia</b> Due to (or as a consequence of): <b>b. Pneumonitis</b> Due to (or as a consequence of): <b>c. Gastrointestinal Hemorrhage</b> Due to (or as a consequence of): <b>d.</b>								Approximate Interval Between Onset and Death <b>1 Day</b> <b>14 Days</b> <b>14 Days</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. <b>atrial fibrillation</b> <b>Congestive Heart failure</b>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <b>Lisa Kim, M.D.</b>				29c. License number <b>D52479</b>		29d. Date signed (Month, Day, Year) <b>August, 14, 2000</b>		
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) <b>DR. LISA KIM, M.D., at Carroll County General Hospital at 200 Memorial Avenue, Westminster, MD 21157</b>								
31. Date filed (Month, Day, Year) <b>AUG 18 2000</b>				32. Registrar's Signature 				



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State of Maryland / Department of Health and Mental Hygiene

00 27683

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Teresa Bernadette Shoemaker				2. Date of Death Month Day Year August 9, 2000		3. Time of Death 8:50 pm	
	4a. Facility Name (If not institution, give street and number) Calvert County Nursing Home				4b. City, Town, or Location of Death Prince Frederick		4c. County of Death Calvert	
Funeral Director	5. Social Security Number 213-74-3859		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 94 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 8, 1905	
	9. Birthplace (State or Foreign Country) Washington, DC		10a. State Maryland		10b. County Calvert		10c. City, Town or Location Prince Frederick	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 85 Hospital Road		10f. Zip Code 20678		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) Eugene Mayhew				18. Mother's Name (First, Middle, Maiden Surname) Ida Howes			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Dan E. Shoemaker - Grandson				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4004 Jefferson St., Hyattsville, MD 20781			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemetery		20c. Location - City or Town, State Brentwood, Maryland		20d. Date 8/14/2000	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee				22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Hepatobiliary Disease Due to (or as a consequence of): b. Diabetes Mellitus Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death Unknown Unknown			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Natural Aging Process				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
To Be Completed by Physician/Medical Examiner	29b. Signature and Title of Certifier				29c. License number D0054076		29d. Date signed (Month, Day, Year) 8/15/00	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rodell Cruise, M.D., 135 W. Dares Beach Road, Prince Frederick, MD 20679							
State Registrar	31. Date filed (Month, Day, Year) AUG 18 2000				32. Registrar's Signature			



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AMEND ITEM: #11 PER F.H. State of Maryland / Department of Health and Mental Hygiene

00 27684

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Clarence Bailey Selke</b>				2. Date of Death Month <b>August</b> Day <b>13</b> Year <b>2000</b>				3. Time of Death <b>10:31 am</b>		
	4a. Facility Name (If not Institution, give street and number) <b>Laurel Regional Hospital</b>				4b. City, Town, or Location of Death <b>Laurel</b>				4c. County of Death <b>Prince George's</b>		
Funeral Director	5. Social Security Number <b>577-10-5165</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>86</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Oct. 18, 1913</b>		9. Birthplace (State or Foreign Country) <b>Washington, DC</b>		
	10a. State <b>Maryland</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>New Carrollton</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
10e. Street and Number <b>8214 Quentin Street</b>		10f. Zip Code <b>20784</b>		10g. Citizen of What Country? <b>U.S.A.</b>							
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Railroad Station Master</b>		16b. Kind of Business/Industry <b>Railroad</b>							
17. Father's Name (First, Middle, Last) <b>Unknown</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Alberta (Unknown)</b>									
19a. Informant's Name/Relationship (Type, Print) <b>James Selke - Son</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8214 Quentin Street, New Carrollton, MD 20784</b>									
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Fort Lincoln Cemetery</b>		20c. Location - City or Town, State <b>8/17/00 Brentwood, MD</b>							
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781</b>									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		a. <b>Myocardial Infarction</b> Due to (or as a consequence of):		minutes							
		b. <b>Hypertension</b> Due to (or as a consequence of):		years							
		c. <b>Diabetes Mellitus</b> Due to (or as a consequence of):		years							
		d.									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Prostate and Bladder Cancer</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred			
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>D43575</b>		29d. Date signed (Month, Day, Year) <b>August 14, 2000</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Angela Duncan, 7350 Van Dusen Road, #130, Laurel, MD 20707</b>		31. Data filed (Month, Day, Year) <b>AUG 16 2000</b>		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

22 Oct 7 1964  
1st Lt. [illegible]  
[illegible]



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27685

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Emily Sacchetti				2. Date of Death Month Day Year August 11 2000				3. Time of Death 1:00 AM	
	4a. Facility Name (If not institution, give street and number) Villa Rosa Nursing Home				4b. City, Town, or Location of Death Mitchellville				4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 165-07-1181		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 102 Yrs.		8. Date of Birth (Month, Day, Year) January 30, 1898		9. Birthplace (State or Foreign Country) Italy	
	Usual Residence of Decedent				10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Mitchellville	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				10e. Street and Number 3800 Lottsford Vista Road				10f. Zip Code 20721	
	10g. Citizen of What Country? USA				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (1-4 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry At Home				17. Father's Name (First, Middle, Last) Donato Cianto	
	18. Mother's Name (First, Middle, Maiden Surname) Rita DeSantis				19a. Informant's Name/Relationship (Type, Print) Louis C. Sacchetti/ Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9881 Century Dr., Ellicott City, Maryland 21042	
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) Entombment				20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery				20c. Location - City or Town, State 08/14/2000 Suitland, Maryland	
	21. Signature of Funeral Service Licensee George P. Kalas				22. Name and Address of Facility George P. Kalas Funeral Home, P.A., 6160 Oxon Hill Road, Oxon Hill, Maryland 20745				23e. Per 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death	
	23a. Immediate Cause (Final disease or condition resulting in death) Atherosclerotic Cardiovascular Disease years				23b. Due to (or as a consequence of): Atrial fibrillation years				23c. Due to (or as a consequence of): Cardiomyopathy years	
	23d. Due to (or as a consequence of):				23e. Due to (or as a consequence of):				23f. Due to (or as a consequence of):	
	23g. Due to (or as a consequence of):				23h. Due to (or as a consequence of):				23i. Due to (or as a consequence of):	
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)				28b. Time of Injury M	
	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				28d. Describe how Injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)	
	28f. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28g. Location (Street and Number or Rural Route Number, City or Town, State)				28h. Location (Street and Number or Rural Route Number, City or Town, State)	
State Registrar	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) as stated.				29b. Signature and title of certifier Rakesh Arora, MD				29c. License number D20108	
	29d. Date signed (Month, Day, Year) 8/12/00				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAKESH ARORA, MD, 14300 GALLANT FOX LN, BOWIE, MD 20715				31. Date filed (Month, Day, Year) AUG 15 2000	
	31. Date filed (Month, Day, Year) AUG 15 2000				32. Registrar's Signature B. B. B.				33. Registrar's Signature B. B. B.	



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27686

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Arthur Joseph STACER				2. Date of Death Month Day Year August 16 2000		3. Time of Death 12:25		
	4a. Facility Name (If not institution, give street and number) Washington County Hospital				4b. City, Town, or Location of Death Hagerstown		4c. County of Death Washington		
Funeral Director	5. Social Security Number 193-09-9381		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 89 Yrs.		8. Date of Birth (Month, Day, Year) Jan. 1, 1911		
	9. Birthplace (State or Foreign Country) Pennsylvania		10a. State Maryland		10b. County Washington		10c. City, Town or Location Hagerstown		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 20024 Gilbert Hills Drive		10f. Zip Code 21742		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) sheet metal worker		16b. Kind of Business/Industry ship yard					
17. Father's Name (First, Middle, Last) Joseph Stacer				18. Mother's Name (First, Middle, Maiden Surname) Bessie Sandsberry					
19a. Informant's Name/Relationship (Type, Print) Raymond Stacer - son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20024 Gilbert Hill Dr., Hagerstown, Md. 21742					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Lawn Mem. Park		Date 8-19-00		20c. Location - City or Town, State Hagerstown, Maryland			
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PNEUMONIA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last EROSIVE ESOPHAGITIS DEMENTIA Due to (or as a consequence of):								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. EROSIVE ESOPHAGITIS DEMENTIA						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number DS2055		29d. Date signed (Month, Day, Year) 8-16-00			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) ZUBAIR M. SYED 368 MILL ST HAGERSTOWN, MD 21740									
31. Date filed (Month, Day, Year) AUG 17 2000		32. Registrar's Signature 							

NAME: STACER,ARTHUR JOSEPH  
DOS:

01/01/1911 89 / M

SYED,ZUBAIR M



H3041979778



H272941

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State of Maryland / Department of Health and Mental Hygiene

00 27687

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>DEBORAH ANN SHANK</b>		2. Date of Death Month Day Year <b>August 12 2000</b>		3. Time of Death <b>3:40 AM</b>
	4a. Facility Name (If not institution, give street and number) <b>THE Johns Hopkins Hospital</b>		4b. City, Town, or Location of Death <b>Baltimore City</b>		4c. County of Death
Funeral Director	5. Social Security Number <b>215-74-2670</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) <b>36</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>Oct. 21, 1963</b>		9. Birthplace (State or Foreign Country) <b>West Virginia</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent		10c. City, Town or Location		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10a. State <b>WV</b>	10b. County <b>Jefferson</b>	<b>Harpers Ferry</b>		
	10e. Street and Number <b>Route 02, Box 1133</b>		10f. Zip Code <b>25425</b>		10g. Citizen of What Country? <b>USA</b>
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Web Master</b>	
16b. Kind of Business/Industry <b>Self-Employed Web Designer</b>		17. Father's Name (First, Middle, Last) <b>Maurice C. Hardy</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Catherine Showen</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Catherine Showen Baer-Mother</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Route 02, Box 788, Harpers Ferry, WV 25425</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Omps Crematory</b>		20c. Location - City or Town, State <b>8/15/2000 Winchester, VA</b>	
21. Signature of Funeral Service Licensee <b>Jean S. Christian</b>		22. Name and Address of Facility <b>Melvin T. Strider Co., Inc. P.O. Box 388, Charles Town, WV 25414</b>			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death
	a. <b>Respiratory Failure</b> Due to (or as a consequence of):				<b>40 min</b>
	b. <b>Pneumonia</b> Due to (or as a consequence of):				
	c. Due to (or as a consequence of):				
d. Due to (or as a consequence of):					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Cerebral Aneurysm</b> <b>Subarachnoid Hemorrhage</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury <b>M</b>	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>MD RES-000</b>		29c. License number <b>August 12, 2000</b>	
29d. Date signed (Month, Day, Year)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Michel Torbay, MD, 601 N Wolfe St., Baltimore, MD 21287</b>			
31. Date filed (Month, Day, Year) <b>AUG 22 2000</b>		32. Registrar's Signature <b>B Sparks</b>			





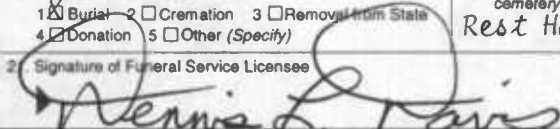
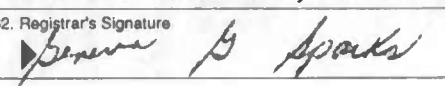
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State of Maryland / Department of Health and Mental Hygiene

00 27688

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Walter Robert Stang</b>				2. Date of Death Month <b>August</b> Day <b>19</b> Year <b>2000</b>				3. Time of Death <b>4:45 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>RAVENWOOD LUTHERAN VILLAGE</b>				4b. City, Town, or Location of Death <b>HAGERSTOWN</b>				4c. County of Death <b>WASHINGTON</b>		
Funeral Director	5. Social Security Number <b>138-16-2996</b>		6. Sex <b>XX</b> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>78</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Nov. 23, 1921</b>		9. Birthplace (State or Foreign Country) <b>New Jersey</b>		
	Usual Residence of Decedent										
10a. State <b>Md.</b>		10b. County <b>Washington</b>		10c. City, Town or Location <b>Smithsburg</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number <b>11906 Haven Hill Dr.</b>				10f. Zip Code <b>21783</b>				10g. Citizen of What Country? <b>U.S.A</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Manufacturing Engineer</b>				16b. Kind of Business/Industry <b>Trucks Co.</b>			
17. Father's Name (First, Middle, Last) <b>Valentine Stang</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Emma Heinz</b>							
19a. Informant's Name/Relationship (Type, Print) <b>Robert W. Stang (Son)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>18718 Northridge Dr. Hagerstown, Md. 21742</b>							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Rest Haven Cemetery</b>		Date <b>Aug. 22, 2000</b>		20c. Location - City or Town, State <b>Hagerstown, Md.</b>					
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>12525 Bradbury Ave. Davis Funeral Home Smithsburg, Md. 21783</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death	
Immediate Cause (Final disease or condition resulting in death) <b>LT. VENTRICULAR DYSFUNCTION</b>										<b>ONE MONTH</b>	
Due to (or as a consequence of): <b>CORONARY ARTERY DISEASE</b>										<b>MANY YEARS</b>	
Due to (or as a consequence of):											
Due to (or as a consequence of):											
Due to (or as a consequence of):											
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>PARKINSONS DISEASE WITH DEMENTIA</b>										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
<b>DIABETIES MELLITUS, NON INSULIN REQUIRING</b>										24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
										24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier 				29c. License number <b>D07857</b>				29d. Date signed (Month, Day, Year) <b>AUGUST 21, 2000</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DR. EDSON MOODY MD., 1190 MT. AETNA RD., HAGERSTOWN, MD. 21740</b>											
31. Date filed (Month, Day, Year) <b>AUG 22 2000</b>		32. Registrar's Signature 									



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27689

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Brandon Michael SHRADER</b>				2. Date of Death Month <b>AUGUST</b> Day <b>19</b> Year <b>2000</b>		3. Time of Death <b>02:30 A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>ROUTE #28 at BUCKLODGE</b>				4b. City, Town, or Location of Death <b>POOLESVILLE</b>		4c. County of Death <b>MONTGOMERY</b>	
Funeral Director	5. Social Security Number <b>218-11-5092</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>14</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>March 23, 1986</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Washington</b>		10c. City, Town or Location <b>Hagerstown</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>712 Park Lane</b>		10f. Zip Code <b>21741</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>0-7</b> College (1-4 or 5+) <b>0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>student</b>		16b. Kind of Business/Industry <b>school</b>				
17. Father's Name (First, Middle, Last) <b>Edward Leroy Shrader</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Andrea Lynn Gore</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Edward L. Shrader - Father</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>712 Park Lane, Hagerstown, Maryland 21741</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Rose Hill Cemetery</b>		Date <b>August 22, 2000</b>		20c. Location - City or Town, State <b>Hagerstown, Maryland</b>		
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Minnich Funeral Home</b> <b>415 East Wilson Blvd., Hagerstown, Maryland 21740</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>Multiple injuries</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.		Approximate Interval Between Onset and Death						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b>						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>8-18-2000</b>		28b. Time of Injury <b>2254</b> M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28d. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Street</b>		28e. Describe how injury occurred <b>subject was passenger of motor vehicle involved in a collision</b>				
		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>Route 28 &amp; Buck Lodge Montgomery County, Maryland</b>						
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>AUGUST 19, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Stephen S. Radentz</b>		<b>111 Penn Street, Baltimore, Maryland 21201</b>						
31. Date filed (Month, Day, Year) <b>AUG 22 2000</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27690

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

EFFIE ELIZABETH STOFFER

2. Date of Death

August 22 2000

3. Time of Death

11:00 PM

4a. Facility Name (If not institution, give street and number)

REEDERS MEMORIAL HOME

4b. City, Town, or Location of Death

BOONSBORO

4c. County of Death

WASHINGTON

Funeral  
Director

5. Social Security Number

219-20-1029

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

JUNE 3, 1909

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

WASHINGTON

10c. City, Town or Location

CHEWSTOWN

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

21103 TWIN SPRINGS DRIVE

10f. Zip Code

21721

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

5

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

JACOB B. MONNINGER

18. Mother's Name (First, Middle, Maiden Surname)

DELLA M. DRURY

19a. Informant's Name/Relationship (Type, Print)

FREDERICK E. STOFFER/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

21101 TWIN SPRING DR., PO BOX 105, CHEWSTOWN, MD 21721

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

BEAVER CREEK CEMETERY

Date

8/25/00

20c. Location - City or Town, State

HAGERSTOWN, MARYLAND

21. Signature of Funeral Service Licensee

Paul M. Dean

22. Name and Address of Facility

BAST FUNERAL HOME

7606 Old National Pike  
Boonsboro, Maryland 2171323a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. SEPSIS

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

3 DAYS

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. BREAST CANCER

Due to (or as a consequence of):

5 YEAR

c. HYPERTENSION

Due to (or as a consequence of):

25 YEAR

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

URINARY TRACT INFECTION

DEHYDRATION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Dr. M. Khalid Waseem

29c. License number

052323

29d. Date signed (Month, Day, Year)

8/23/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. M. Khalid Waseem 19414C Leithersburg Pike, Hagerstown, Maryland 21742/240-420-2666

State  
Registrar

31. Date filed (Month, Day, Year)

AUG 23 2000

32. Registrar's Signature

Dr. M. Khalid Waseem

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Name: Effie Elizabeth Stoffer  
Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
2025.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27691

amend item 8 per fh G786 8/31/00 yf

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Helen May Stewart</b>				2. Date of Death Month Day Year <b>July 7, 2000</b>				3. Time of Death <b>11:20 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Vindobona Nursing Home</b>				4b. City, Town, or Location of Death <b>Braddock Heights</b>				4c. County of Death <b>Frederick</b>	
Funeral Director	5. Social Security Number <b>210-14-1678</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>88</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>3/1/1912</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent				10a. State <b>Maryland</b>		10b. County <b>Frederick</b>		10c. City, Town or Location <b>Frederick</b>	
10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number <b>36 East 6th Street</b>				10f. Zip Code <b>21701</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4or 5+) <b>secretary</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>law practice</b>				16b. Kind of Business/Industry		
17. Father's Name (First, Middle, Last) <b>John H. Stewart</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lucy May Topper</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Peggy S. Ligocki</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2502 Driftwood Court, #1C, Frederick, MD 21702</b>						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Olivet Cemetery</b>				20c. Location - City or Town, State <b>07/11/00 Frederick, Maryland</b>		
21. Signature of Funeral Service Licensee <b>Ryan M. Beeger</b> M00999				22. Name and Address of Facility <b>Keeney and Basford Funeral Home</b> <b>106 East Church Street, Frederick, MD 21701</b>						
23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Cerebrovascular Accident</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Chronic Monomyelocytic Leukemia</b> <b>Severe Osteoporosis</b>				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				Approximate Interval Between Onset and Death <b>48 hours</b>		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <b>Mary P. Howell MD</b>				29c. License number <b>046075</b>		
29d. Date signed (Month, Day, Year) <b>7/10/2000</b>				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>170 THOMAS JOHNSON DR #100 FREDERICK MD 21702</b>						
31. Date filed (Month, Day, Year) <b>JUL 11 2000</b>				32. Registrar's Signature <b>[Signature]</b>						

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend Item #21,22 per FHG787 9/5/2000 EW  
Amend #21,22 as per Funeral Home 8/22/00 CCHD

State of Maryland / Department of Health and Mental Hygiene

00 27692

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Laura Tellechea</b>				2. Date of Death Month Day Year <b>AUG 19 2000</b>		3. Time of Death <b>11:07 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>CIVISTA MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>LAPLATA</b>		4c. County of Death <b>CHARLES</b>	
Funeral Director	5. Social Security Number <b>157-20-5751</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>72</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>02/01/1928</b>	9. Birthplace (State or Foreign Country) <b>New York</b>			
	Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>Charles</b>		10c. City, Town or Location <b>La Plata</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>One Magnolia Drive</b>				10f. Zip Code <b>20646</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Home Maker</b>		16b. Kind of Business/Industry <b>Own Home</b>		
17. Father's Name (First, Middle, Last) <b>Benjamin Fishman</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mollie Benshinity</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Patricia Tellechea/Dghtr</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>518 East 139th Street Bronx NY</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Rosedale Cemetery</b>		20c. Location - City or Town, State <b>8/24/00 Linden NJ</b>				
21. Signature of Funeral Service Licensee <i>[Signature]</i> <b>MD0173</b>				22. Name and Address of Facility <b>Eberwein Funeral Services</b> <b>4433 White Plains Lane White Plains, MD 20695</b> <b>LaPaz Funeral Svc 285 E149th Street BK NY</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Chronic Renal Failure</b> <b>Advanced Atherosclerosis</b>				Approximate Interval Between Onset and Death <b>x 5 mo</b> <b>x yrs.</b>				
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>[Signature]</i>				
29c. License number <b>D-20629</b>				29d. Date signed (Month, Day, Year) <b>8/20/00</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>GEORGE H WATHEN MD 11345 PEMBROOKE SQ.SUITE 103 WALDORF, MD 20603</b>								
31. Date filed (Month, Day, Year) <b>AUG 22 2000</b>				32. Registrar's Signature <i>[Signature]</i>				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.



Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Javier Gerardo Tascano</b>				2. Date of Death Month <b>AUGUST</b> Day <b>16</b> , Year <b>2000</b>		3. Time of Death <b>1328 PM.</b>		
	4a. Facility Name (If not institution, give street and number) <b>2700 ROLLING ROAD</b>				4b. City, Town, or Location of Death <b>WOODLAWN</b>		4c. County of Death <b>BALTIMORE</b>		
Funeral Director	5. Social Security Number <b>None</b>		6. Sex <b>1</b> M <b>2</b> F		7. Age (in yrs. last birthday) <b>27</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Mar. 26, 1973</b>		
	9. Birthplace (State or Foreign Country) <b>Mexico</b>		10a. State <b>Md.</b>		10b. County <b>Prince Georges</b>		10c. City, Town or Location <b>Riverdale</b>		
10d. Inside City Limits <b>1</b> Yes <b>2</b> No		10e. Street and Number <b>5516 Madison St., Apt. 201</b>		10f. Zip Code <b>20737</b>		10g. Citizen of What Country? <b>Mexico</b>			
11. Marital Status <b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> Yes <b>2</b> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> Yes <b>2</b> No Specify: <b>Mexican</b>		14. Race - American Indian, Black, White, etc. Specify: <b>Hispanic</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Laborer</b>		16b. Kind of Business/Industry <b>Construction</b>					
17. Father's Name (First, Middle, Last) <b>Eleazar Tascano</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Maria Teresa Barragan</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Gerardo Contreras</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6407 25th St. N. Arlington, Va. 22207</b>					
20a. Method of Disposition <b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Municipal Cemetery</b>		Date <b>8/25/00</b>		20c. Location - City or Town, State <b>Mexico City, Mexico</b>			
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Professional Mortuary Services 612 Trent Dr., Durham, N.C. 27715</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>MULTIPLE INJURIES</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown			
						24a. Was an autopsy performed? <b>1</b> Yes <b>2</b> No			
						24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> Yes <b>2</b> No			
25. Was case referred to medical examiner? <b>1</b> Yes <b>2</b> No		26. Place of Death (Check only one) Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify) <b>AT SCENE</b>							
27. Manner of Death <b>1</b> Natural <b>5</b> Pending investigation <b>2</b> Accident <b>6</b> Could not be determined <b>3</b> Suicide <b>4</b> Homicide		28a. Date of Injury (Month, Day, Year) <b>8/16/00</b>		28b. Time of Injury <b>1:37 PM</b>		28c. Injury at Work? <b>1</b> Yes <b>2</b> No			
28d. Describe how injury occurred <b>CINDER BLOCK WALL FELL ON SUBJECT</b>		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>INDUSTRIAL AREA/CONSTRUCTION SITE</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>2700 ROLLING RD WOODLAWN, MD.</b>					
29a. Certifier (Check only one) <b>2</b> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 							
29c. License number <b>OCME</b>		29d. Date signed (Month, Day, Year) <b>AUGUST 17, 2000</b>							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MARY G. RIPLEY, M.D. 111 Penn Street, Baltimore, Maryland 21201</b>									
31. Date filed (Month, Day, Year) <b>AUG 18 2000</b>		32. Registrar's Signature 							

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27694

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Hilda Antoinette Talcott				2. Date of Death Month Day Year August 11, 2000				3. Time of Death 11:10 A.M.	
	4a. Facility Name (If not institution, give street and number) Brighton Gardens				4b. City, Town, or Location of Death Bethesda				4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 215-50-3052	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) July 3, 1912		9. Birthplace (State or Foreign Country) New York		
	Usual Residence of Decedent									
10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Rockville				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 1705 Glastonberry Road				10f. Zip Code 20854		10g. Citizen of What Country? USA				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Private			
17. Father's Name (First, Middle, Last) Max Cwillinger				18. Mother's Name (First, Middle, Maiden Surname) Josephine Jezso						
19a. Informant's Name/Relationship (Type, Print) Jan Provost / Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1705 Glastonberry Road Rockville, Maryland 20854						
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemetery		Date 8-15-00		20c. Location - City or Town, State Brentwood, Maryland		
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Road 20722						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <u>Dementia</u> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death  years	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Hypertension</u>								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of injury (Month, Day Year)		28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <i>Ellen M Pinholt MD</i>				29c. License number D51015			29d. Date signed (Month, Day, Year) August 15, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Ellen M Pinholt 5530 Wisconsin Ave #1045 Chevy Chase MD 20815</i>										
31. Date filed (Month, Day, Year) AUG 16 2000				32. Registrar's Signature <i>[Signature]</i>						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

00 27695

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Beverly A. Teasley-Holton				2. Date of Death Month Day Year Aug 10, 2000		3. Time of Death 11:00AM		
	4a. Facility Name (If not institution, give street and number) Gladys Spellman Speciality Hospital				4b. City, Town, or Location of Death Cheverly		4c. County of Death Prince George's		
Funeral Director	5. Social Security Number 577-78-8544		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 43 Yrs.		8. Date of Birth (Month, Day, Year) Aug 2, 1957		
	9. Birthplace (State or Foreign Country) Washington DC		10a. State MD		10b. County Prince George's		10c. City, Town or Location Landover		
Usual Residence of Decedent		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 6708 Vermont Court		10f. Zip Code 20785		10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife		16b. Kind of Business/Industry Private					
17. Father's Name (First, Middle, Last) Precy Teasley				18. Mother's Name (First, Middle, Maiden Surname) Christine Terrell					
19a. Informant's Name/Relationship (Type, Print) Christine Teasley- Mother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6708 Vermont Court Landover MD 20785					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Ft. Lincoln		Date 8-17-00		20c. Location - City or Town, State Brentwood, MD			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility J.B. Jenkins Funeral Home 7474 Landover Rd Landover MD 20785					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Human Immunodeficiency Virus Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death years	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Encephalopathy Renal Failure						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number D01852		29d. Date signed (Month, Day, Year) August 10 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul A. DeVore MD 4203 Queensbury Rd Hyattsville MD 20781		31. Date filed (Month, Day, Year) AUG 15 2000		32. Registrar's Signature 					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

PER MEO G787 9-7-00 WR.

Certificate of Death

Reg. No.

00 27696

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

BONNIE LOUISE TULL

2. Date of Death

Month Day Year  
August 27, 2000

3. Time of Death

2:50 A.M.

4a. Facility Name (If not institution, give street and number)

McCready Memorial Hospital

4b. City, Town, or Location of Death

Crisfield

4c. County of Death

Somerset

Funeral  
Director

5. Social Security Number

218-50-1949

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

52

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
June 6, 1948

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Somerset

10c. City, Town or Location

Crisfield

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

413 Myrtle St.

10f. Zip Code

21817

10g. Citizen of What Country?

USA

11. Marital Status

☒ Never Married ☐ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
10

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Care Giver

16b. Kind of Business/Industry

Home Care

17. Father's Name (First, Middle, Last)

Norris J. Tull

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Sterling

19a. Informant's Name/Relationship (Type, Print)

Tammy L. Tull-Mister (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4511 Briarwood Circle - Crisfield, MD 21817

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Sunnyridge Memorial Park 8/30/00

Date

20c. Location - City or Town, State

Crisfield, MD

21. Signature of Funeral Service Licensee

Robert H. Bradshaw

22. Name and Address of Facility

Bradshaw & Sons Funeral Home  
306 W. Main St. - Crisfield, MD 21817

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

MIXED DRUG INTOXICATION

Approximate  
Interval Between  
Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☒ Yes ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

☒ Yes ☐ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

Hospital:

☐ Inpatient ☒ Outpatient ☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☐ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☒ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day, Year)  
FOUND: 8-27-00

28b. Time of Injury

UNKNOWN

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

SUBJECT INGESTED DRUGS

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

HOME

28f. Location (Street and Number or Rural Route Number, City or Town, State)

413 MYRTLE ST. CRISFIELD, MD

29a. Certifier  
(Check only one)☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Robert H. Bradshaw

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

August 28, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. C. STONER

111 Penn Street, Baltimore, Maryland 21201

State  
Registrar

31. Date filed (Month, Day, Year)

AUG 30 2000

32. Registrar's Signature

Benjamin G. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1941 10 10 1700

1941 10 10 1700

X

Standard

Standard

1941

1941

1941

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X

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1941 10 10 1700

1941 10 10 1700

1941 10 10 1700

1941 10 10 1700

1941 10 10 1700



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27697

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

GILBERT TANNER

2. Date of Death

Month

Day

Year

8 10 2000

3. Time of Death

6-30 A.M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

1711 HARBOR DR

4b. City, Town, or Location of Death

CHESTER

4c. County of Death

QUEEN ANNE'S

5. Social Security Number

288-09-3407

6. Sex

M ☒ F ☐

7. Age (in yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

06 27 1917

9. Birthplace (State or Foreign Country)

GA

Usual Residence of Decedent

10a. State

FLA

10b. County

POLK COUNTY

10c. City, Town or Location

WINTER HAVEN

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

# 1 HIDE A WAY LANE

10f. Zip Code

33880

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

AUTO REPAIR

16b. Kind of Business/Industry

AUTOMOTIVE

17. Father's Name (First, Middle, Last)

WILLIAM G. TANNER

18. Mother's Name (First, Middle, Maiden Surname)

BESSIE BLOSSOM NICOLA

19a. Informant's Name/Relationship (Type, Print)

JANICE RODANO/ DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1711 HARBOR DR, CHESTER MD 21619

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

crematory, crematory or other place)

CHESAPEAKE CREMATORY

Date

8/11/2000

20c. Location - City or Town, State

STEVENSVILLE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA  
106 SHAMROCK RD, CHESTER MD 21619

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

metastatic lung cancer to the

Due to (or as a consequence of):

Livers and Brain.

Due to (or as a consequence of):

Small cell cancer of the right

Due to (or as a consequence of):

Lung.

3 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Renal Mass

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☒ Other (Specify)

Daughter's house

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 21294

29d. Date signed (Month, Day, Year)

8/10/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ABDUL NAYEEM M.D. 3450 FORT MEADE ROAD, LAUREL MD

31. Date filed (Month, Day, Year)

AUG 11 2000

32. Registrar's Signature

20724

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or item 23a or 23e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27698

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

SUSAN MARGARET VISLEY

2. Date of Death  
Month Day Year  
AUGUST 21 20003. Time of Death  
2:20 PM

4a. Facility Name (If not institution, give street and number)

CIVISTA MEDICAL CENTER

4b. City, Town, or Location of Death

LA PLATA

4c. County of Death

CHARLES

Funeral  
Director

5. Social Security Number

195-38-0420

6. Sex  
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85

If Under 1 Year  
Months DaysIf Under 24 Hrs.  
Hours Min.8. Date of Birth  
(Month, Day, Year)

FEB 12 1915

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State  
Maryland10b. County  
Charles10c. City, Town or Location  
Waldorf10d. Inside City Limits  
1 ☐ Yes 2 ☒ No10e. Street and Number  
4140 Old Washington Rd  
Waldorf Health Care

10f. Zip Code

20601

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (14 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Andrew Tomko

18. Mother's Name (First, Middle, Maiden Summa)

Susan Vallo Tomko

19a. Informant's Name/Relationship (Type, Print)

Betty J. Hayes (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

137 Jefferson Road Waldorf, MD 20602

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

St Gertrude Ch. Cem.

Date

8-25-00

20c. Location - City or Town, State

Vandergrift, PA

21. Signature of Funeral Service Licensee

M00173

22. Name and Address of Facility

Eberwein Funeral Services  
4433 White Pls. La. White Pls., MD 2069523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
stroke, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. BREAST CANCER

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Dr. M. Hatten

29c. License number

D28352

29d. Date signed (Month, Day, Year)

8/21/00

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

PO Box 2729 La Plata Md 20646

31. Date filed (Month, Day, Year)

AUG 22 2000

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
202-358-2020.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27699

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Evangeline H. Vannall

2. Date of Death

Month  
August

Day

11

Year

2000

3. Time of Death

11:05PM

4a. Facility Name (If not institution, give street and number)

Casey House - 6001 Muncaster Mill Road

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

060-32-1343

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

65 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 24, 1935

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Fort Washington

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

13307 Warburton Drive

10f. Zip Code

20744

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Day Care Provider

16b. Kind of Business/Industry

Self-Employed

17. Father's Name (First, Middle, Last)

Bonnie Harris

18. Mother's Name (First, Middle, Maiden Surname)

Fannie Odom

19a. Informant's Name/Relationship (Type, Print)

Bonnie L. Harris - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13307 Warburton Dr., Ft. Wash., MD 20744

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Branches Chapel Cem.

Date

8/18/2000

20c. Location - City or Town, State

Rich Square, NC

21. Signature of Funeral Service Licensee

John T. Stewart III

22. Name and Address of Facility

Stewart Funeral Home

4001 Benning Rd., N.E. Wash., D.C. 20019

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Multiple Myeloma

Approximate Interval Between Onset and Death

5 1/2 Years

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Mark S. Godec, M.D.

29c. License number

D0037620

29d. Date signed (Month, Day, Year)

August 12, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mark S. Godec, M.D. - Casey House-6001 Muncaster Mill Rd., Rockville, MD 20855

31. Date filed (Month, Day, Year)

AUG 15 2000

32. Registrar's Signature

B. Spates

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27700

Amend #5. Per FH PGC 8-15-2000 cr

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DAVID JOSEPH VAUGHN

2. Date of Death

AUGUST 7, 2000

3. Time of Death

17:45

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

PRINCE GEORGE'S HOSPITAL

4b. City, Town, or Location of Death

CHEVERLY

4c. County of Death

PRINCE GEORGE

5. Social Security Number

227-34-9006

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

APRIL 6, 1930

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State  
MARYLAND

10b. County

PRINCE GEORGE

10c. City, Town or Location

LARGO

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

11312 WHITE HOUSE ROAD

10f. Zip Code

20772

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: 194813. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: BLACK

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

CHEF

16b. Kind of Business/Industry

FOOD SERVICE

17. Father's Name (First, Middle, Last)

WILLIAM FREDRICK VAUGHN

18. Mother's Name (First, Middle, Maiden Surname)

EMMA MAE KEYS

19a. Informant's Name/Relationship (Type, Print)

TAMI L. McDUFFIE/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9731 COPPERWAY STREET CONVERSE, TEXAS 78109

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

FORT LINCOLN CEMETERY

Date

8/11/2000 BRENTWOOD, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

FORT LINCOLN FUNERAL HOME

3401 BLADENSBURG RD. BRENTWOOD, MARYLAND 20722

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

Intracerebral Hemorrhage days

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D 30318

29d. Date signed (Month, Day, Year)

8/7/00

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

James Catavenis M.D. 3001 Hospital Drive Cheverly, Maryland 20785

31. Date filed (Month, Day, Year)

AUG 14 2000

32. Registrar's Signature

Beyonce S. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10-7-74

10-7-74

10-7-74

10-7-74

10-7-74

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27701

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CATHERINE

DOROTHY

WARD

2. Date of Death

Month

Day

Year

AUGUST

19

2000

3. Time of Death

10:15A.M.

4a. Facility Name (If not institution, give street and number)

CIVISTA MEDICAL CENTER

4b. City, Town, or Location of Death

LA PLATA

4c. County of Death

CHARLES

Funeral  
Director

5. Social Security Number

215-26-2869

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

November 19, 1913

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Charles

10c. City, Town or Location

Welcome

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7053 Port Tobacco Road

10f. Zip Code

20693

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working  
life. DO NOT use retired)

Owner/Sales Clerk

16b. Kind of Business/Industry

General Store

17. Father's Name (First, Middle, Last)

Francis C. Rice

18. Mother's Name (First, Middle, Maiden Surname)

Anna C. Winkler Rice

19a. Informant's Name/Relationship (Type, Print)

Fred B. Ward/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7053 Port Tobacco Rd. Welcome, MD 20693

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Cem. St. Ignatius Chapel Pt. 8/23/00 Port Tobacco, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

David C. Ehrlich

M00945

22. Name and Address of Facility

AREHART-ECHOLS FUNERAL HOME, P.A.  
P.O. BOX 567 LA PLATA, MD. 2064623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. PNEUMONIA.

Due to (or as a consequence of):

b. CHRONIC ATROPHIC FIBROSIS x 5 YRS

Due to (or as a consequence of):

c. OLD Cerebral Vascular Accidents LEFT SIDE WEAK x 5 YRS.

Due to (or as a consequence of):

d. DIABETES MELLITUS. ADULT ONSET x 5 YRS.

Approximate  
Interval Between  
Onset and Death

x 3 WKS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

George H. Wathen M.D.

29c. License number

D-20629

29d. Date signed (Month, Day, Year)

8/19/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GEORGE H. WATHEN M.D. 11345 PEMBROOKE SQUARE WALDORF MARYLAND 20603

31. Date filed (Month, Day, Year)

AUG 21 2000

32. Registrar's Signature

Beverly S. Sparks

State  
RegistrarCATHERINE WARD  
Baltimore, Maryland 21215-0020permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
card.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 00 27702

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CATHERINE GARNER WILLIAMS

2. Date of Death

AUGUST 16, 2000 12:40 AM

3. Time of Death

4a. Facility Name (If not institution, give street and number)

CIVISTA MEDICAL CENTER

4b. City, Town, or Location of Death

LAPLATA

4c. County of Death

CHARLES

Funeral  
Director

5. Social Security Number

220-54-0431

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

50

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

6. Date of Birth

FEBRUARY 13, 1950

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

CHARLES

10c. City, Town or Location

WHITE PLAINS

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

P.O. BOX 100 OLD FAIR GROUNDS ROAD

10f. Zip Code

20695

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

CUSTOMER SERVICE REPRESENTATIVE ADMINISTRATION

16b. Kind of Business/Industry

MOTOR VEHICLE

ADMINISTRATION

17. Father's Name (First, Middle, Last)

PAUL THEODORE GARNER

18. Mother's Name (First, Middle, Maiden Surname)

DORA IRENE OLIVER

19a. Informant's Name/Relationship (Type, Print)

STEVEN L. GARNER/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. BOX 100 OLD FAIR GROUNDS RD., WHITE PLAINS, MD 20695

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

MARYLAND VETERANS CEMETERY 8/21/2000 CHELTENHAM, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

JOHN P. KNISLEY

M01164

22. Name and Address of Facility

THE HUNTT FUNERAL HOME, INC., POST OFFICE BOX 156, WALDORF, MARYLAND 20604-0156

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. RESPIRATORY FAILURE

3 mos

Due to (or as a consequence of):

b. METASTATIC SARCOMA

6 mos

Due to (or as a consequence of):

c. SARCOMA OF THE UTERUS

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Joel Sewchand MD, P.C.

29c. License number

D-29646

29d. Date signed (Month, Day, Year)

August 17, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joel Sewchand, MD 118 La Grange Avenue, P.O. Box 975, La Plata, Maryland 20646

State  
Registrar

31. Date filed (Month, Day, Year)

AUG 21 2000

32. Registrar's Signature

B. Sparks

ORIGINAL

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

JPK





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27703

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JANETTE ONETTA WINTERS</b>				2. Date of Death Month <b>AUGUST</b> Day <b>20</b> Year <b>2000</b>		3. Time of Death <b>1543</b>	
	4a. Facility Name (If not institution, give street and number) <b>SOUTHERN MARYLAND HOSP. CENTER</b>				4b. City, Town, or Location of Death <b>CLINTON</b>		4c. County of Death <b>PRINCE GEORGE</b>	
Funeral Director	5. Social Security Number <b>220-38-4981</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>58</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>OCT. 9, 1941</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>
	Usual Residence of Decedent							
10a. State <b>MARYLAND</b>		10b. County <b>CHARLES</b>		10c. City, Town or Location <b>WALDORF</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>5024 NICHOLAS ROAD</b>				10f. Zip Code <b>20601</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>COMPUTER PRINTER OPERATOR EMBASSY DAIRY CO.</b>		16b. Kind of Business/Industry		
17. Father's Name (First, Middle, Last) <b>GEORGE FRANKLIN KITTS</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>JESSIE ELIZABETH LAMBERT</b>				
19a. Informant's Name/Relationship (Type, Print) <b>KENNETH WINTERS-SPOUSE</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>SAME AS #10</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>TRINITY MEMORIAL GARDEN 8-24-00 WALDORF, MD.</b>		Data		20c. Location - City or Town, State		
21. Signature of Funeral Service Licensee <b>MO0479</b> <i>Michael O. Raymond</i>				22. Name and Address of Facility <b>RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Acute Myocardial Infarction</b> Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypercholesterolemia</b> <b>Diabetes</b> <b>Hypertension</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>TERRY JODRIE</i>		29c. License number <b>D40324</b>		29d. Date signed (Month, Day, Year) <b>August 20, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>TERRY JODRIE, M.D., SOUTHERN MARYLAND HOSPITAL CENTER, CLINTON MARYLAND</b>								
31. Date filed (Month, Day, Year) <b>AUG 22 2000</b>		32. Registrar's Signature <i>G. Sparks</i>						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27704

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) William R. West				2. Date of Death Month Day Year AUGUST 15 2000		3. Time of Death 8:10 AM				
	4a. Facility Name (If not institution, give street and number) 13201 B OLD INDIANHEAD ROAD				4b. City, Town, or Location of Death BRANDYWINE		4c. County of Death PRINCE GEORGE'S				
Funeral Director	5. Social Security Number 579-30-1949		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 72 Yrs.		8. Date of Birth (Month, Day, Year) July 24, 1928		9. Birthplace (State or Foreign Country) Washington, DC		
	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Washington, DC				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No						
10e. Street and Number 130 56th Street SE				10f. Zip Code 20019		10g. Citizen of What Country? United States					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 2/46-8/47		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Pouch Carrier		16b. Kind of Business/Industry U.S. Government					
17. Father's Name (First, Middle, Last) James West				18. Mother's Name (First, Middle, Maiden Surname) Hollis Spriggs							
19a. Informant's Name/Relationship (Type, Print) Thomas W. Queens, Jr./Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 627 Dunkirk, Maryland 20754							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Lincoln Memorial Cemetery		20c. Location - City or Town, State Suitland, Md.		20d. Date 8/21/00			
21. Signature of Funeral Service Licensee <i>Stacy A. Natchez</i>				22. Name and Address of Facility Alexander S. Pope Funeral Homes 5538 Marlboro Pike/Forestville, Md. 20747							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <u>Hyper-tensive atherosclerotic Cardiovascular disease</u> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____				Approximate Interval Between Onset and Death							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>Stacy A. Natchez, M.D.</i>				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) AUGUST 16, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201											
31. Date filed (Month, Day, Year) AUG 17 2000				32. Registrar's Signature <i>Benjamin B. Smith</i>							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.



3 copies

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27705

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CAMILIA WILLIAMS				2. Date of Death Month Day Year Aug 10 2000		3. Time of Death 2130			
	4a. Facility Name (If not Institution, give street and number) Laurel Regional Hospital				4b. City, Town, or Location of Death Laurel		4c. County of Death Prince George's			
Funeral Director	5. Social Security Number 063-56-1437		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 66 Yrs.		8. Date of Birth (Month, Day, Year) May 7, 1934		9. Birthplace (State or Foreign Country) Alabama	
	Usual Residence of Decedent									
10a. State MD		10b. County Prince Georges		10c. City, Town or Location Laurel				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 501 Main St				10f. Zip Code 20707		10g. Citizen of What Country? USA				
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0 College (1-4 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Unemployed			16b. Kind of Business/Industry None			
17. Father's Name (First, Middle, Last) Samuel Snow				18. Mother's Name (First, Middle, Maiden Surname) Magnolia McBride						
19a. Informant's Name/Relationship (Type, Print) Mary Taylor (Daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 501 Main St Laurel Md 20707						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Kensico Cemetery		20c. Date 8-14-00		20d. Location - City or Town, State Valhalla N.Y.			
21. Signature of Funeral Service Licensee [Signature]				22. Name and Address of Facility Hawthorne Funeral Home 21 Stevens Ave Hawthorne NY						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Aspiration Pneumonia Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death HRS		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Seizure Disorder, CHF							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier [Signature]			29c. License number D28998		29d. Date signed (Month, Day, Year) Aug 11, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PRITAM SIANI MD 9101 Cherry LN Suite 211 Laurel MD 20708										
31. Date filed (Month, Day, Year) AUG 17 2000			32. Registrar's Signature [Signature]							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27706

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Paul J. Wencel				2. Date of Death Month Day Year August 14, 2000				3. Time of Death 3:25PM	
	4a. Facility Name (If not institution, give street and number) Larkin Chase Nursing&Rehabilitation Center				4b. City, Town, or Location of Death Bowie				4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 579-01-9556		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 16, 1915		9. Birthplace (State or Foreign Country) Michigan	
	Usual Residence of Decedent									
10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Temple Hills				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 4804 Henderson Road				10f. Zip Code 20748				10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No WWII If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Superintendent				16b. Kind of Business/Industry Construction		
17. Father's Name (First, Middle, Last) John Matthew Wencel					18. Mother's Name (First, Middle, Maiden Surname) Clara Amelia Walkey					
19a. Informant's Name/Relationship (Type, Print) Jane H. Wencel/Wife					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as item 10					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cemetery 8/17/2000 Cheltenham, Md.				20c. Location - City or Town, State		
21. Signature of Funeral Service Licensee <i>George P. Kalas, Jr.</i>				22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd. Oxon Hill, Md. 20745						
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Dementia Due to (or as a consequence of):  peripheral vascular disease Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  Approximate Interval Between Onset and Death Yrs Yrs										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) as stated.										
29b. Signature and title of certifier <i>N. J. ... MD</i>				29c. License number N41978				29d. Date signed (Month, Day, Year) 8-15-2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nadel ... 1 Hosp ... MD 20785										
31. Date filed (Month, Day, Year) AUG 16 2000		32. Registrar's Signature <i>...</i>								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27707

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Douglas Julian Whitney				2. Date of Death Month Day Year August 11, 2000				3. Time of Death 11:20 A.M.			
	4a. Facility Name (If not institution, give street and number) Doctors Community Hospital				4b. City, Town, or Location of Death Lanham				4c. County of Death Prince Georges			
Funeral Director	5. Social Security Number 225-70-1348		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 52 Yrs.		8. Date of Birth (Month, Day, Year) February 5, 1948		9. Birthplace (State or Foreign Country) Maine			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10e. State Maryland		10b. County Prince Georges		10c. City, Town or Location Hyattsville				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number 5005 37th Place				10f. Zip Code 20782		10g. Citizen of What Country? USA					
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: Viet Nam		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Safety Specialist				16b. Kind of Business/Industry St. Elizabeth Hospital			
	17. Father's Name (First, Middle, Last) Cecil Whitney				18. Mother's Name (First, Middle, Maiden Surname) Marguerite Delany							
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Debbie A. Whitney / Spouse				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5005 37th Place Hyattsville, MD 20782							
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Ft. Lincoln Crematory August 16, 2000 Brentwood, MD		20c. Location - City or Town, State							
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Ft. Lincoln Funeral Home 3401 Bladensburg Rd. Brentwood, MD 20722							
	23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Hypoxia Aspergillus Pneumonia Multiple Myeloma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Chronic Renal Insufficiency										Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Renal Insufficiency										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
State Registrar	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)									
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										29c. License number D48200	
	29b. Signature and title of certifier MD				29d. Data signed (Month, Day, Year) 8-15-00							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALEX ANDERS 8824 CUNNINGHAM DR #B BETHYNN HTS, MD 20780												
31. Date filed (Month, Day, Year) AUG 16 2000		32. Registrar's Signature 										

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27708

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JOSEPH RAYMOND WATTS, JR.</b>				2. Date of Death Month <b>August</b> Day <b>10</b> Year <b>2000</b>		3. Time of Death <b>1830 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>2713 Wood Hollow Place</b>				4b. City, Town, or Location of Death <b>Fort Washington</b>		4c. County of Death <b>Prince George's</b>	
Funeral Director	5. Social Security Number <b>579-94-6625</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>23</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>August 23, 1976</b>	
	9. Birthplace (State or Foreign Country) <b>Washington, DC</b>		10a. State <b>Maryland</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Fort Washington</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10a. Street and Number <b>2713 Wood Hollow Place</b>		10f. Zip Code <b>20744</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yea or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yea <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/> <b>1 Year</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Printer</b>		16b. Kind of Business/Industry <b>Private</b>			
	17. Father's Name (First, Middle, Last) <b>Joseph Raymond Watts, Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Georgetta Willis</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Georgetta Watts/Mother</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9154 Piscataway Road, Clinton, Maryland 20735</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Washington National Ceme.</b>		Date <b>08/15 2000</b>		20c. Location - City or Town, State <b>Suitland, Maryland</b>	
	21. Signature of Funeral Service Licensee <b>Nancy A. Perente</b>		22. Name and Address of Facility <b>J.B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>Hanging, Self-inflicted</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Ethanol Abuse</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>Aug. 10, 2000</b>		28b. Time of Injury <b>1830 PM</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred <b>Hanging from electrical cord tied to ceiling beam</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>2713 Wood Hollow Place Fort Washington, MD</b>						
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <b>Salvador Sylvester, MD</b>				29c. License number <b>H0055927</b>		29d. Date signed (Month, Day, Year) <b>August 11, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Salvador Sylvester, MD, ME, 3001 Hospital Drive, Cheverly, Maryland 20785</b>								
State Registrar	31. Date filed (Month, Day, Year) <b>AUG 15 2000</b>		32. Registrar's Signature <b>[Signature]</b>					

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State of Maryland / Department of Health and Mental Hygiene

00 27709

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MARGARET B. WOODS.</b>				2. Date of Death Month <b>08</b> Day <b>13</b> Year <b>2000</b>		3. Time of Death <b>3:55PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Southern Maryland Hospital Center</b>				4b. City, Town, or Location of Death <b>Clinton</b>		4c. County of Death <b>Prince George's</b>	
Funeral Director	5. Social Security Number <b>577-30-0767</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>73</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Dec. 9, 1926</b>	
	9. Birthplace (State or Foreign Country) <b>Virginia</b>		10a. State <b>Maryland</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Forestville</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>2502 Roslyn Ave.</b>		10f. Zip Code <b>20747</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11th</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Head Cashier</b>		16b. Kind of Business/Industry <b>Sears, Roebuck Co.</b>		17. Father's Name (First, Middle, Last) <b>William W. Payne</b>	
	18. Mother's Name (First, Middle, Maiden Surname) <b>Minnie M. Ryan</b>		19a. Informant's Name/Relationship (Type, Print) <b>Keith E. Payne/Brother</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1021 Melrose Road Lottsburg, VA. 22511</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cedar Hill Cemetery</b>		20c. Date <b>8/17/2000</b>		20d. Location - City or Town, State <b>Cedar Hill Cemetery</b>		21. Signature of Funeral Service Licensee <i>[Signature]</i>	
	22. Name and Address of Facility <b>George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd. Oxon Hill, Md. 20745</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause of each line. <b>a. MULTI ORGAN FAILURE</b> Due to (or as a consequence of): <b>b. SHOCK, RESPIRATORY FAILURE, RENAL FAILURE</b> Due to (or as a consequence of): <b>c. SHOCK LIVER, ACIDOSIS, COAGULOPATHY,</b> Due to (or as a consequence of): <b>d. ANEMIA, RHABDOMYOLYSIS.</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		23c. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	23d. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>INTRACEREBRAL HEMATOMA, DIABETES, HYPOTHYROID, MYASTHENIA GRAVIS, VASCULAR DISEASE, HYPERLIPIDEMIA, OLD CEREBROVASCULAR ACCIDENT, GASTROESOPHAGEAL REFLUX</b>		24b. Date of Injury (Month, Day, Year) <b>8/13/2000</b>		24c. Time of Injury <b>M</b>	
	24d. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24e. Describe how injury occurred		24f. Location (Street and Number or Rural Route Number, City or Town, State)		24g. Date signed (Month, Day, Year)	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27a. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		27b. Pending investigation <input type="checkbox"/> Could not be determined	
	27c. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		27d. Signature and title of certifier <b>G. Srinivasan, M.D.</b>		27e. License number <b>D0046345</b>		27f. Date signed (Month, Day, Year) <b>8/13/2000</b>	
To Be Completed by Physician/Medical Examiner	28a. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>G. Srinivasan, M.D. 3600 Leonardtown Rd. #103 Waldorf, Md. 20601</b>		28b. Date of Injury (Month, Day, Year) <b>8/13/2000</b>		28c. Time of Injury <b>M</b>		28d. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		28g. Date signed (Month, Day, Year)		28h. Time of Injury	
To Be Completed by Physician/Medical Examiner	29a. Date filed (Month, Day, Year) <b>AUG 15 2000</b>		29b. Registrar's Signature <i>[Signature]</i>		29c. License number <b>D0046345</b>		29d. Date signed (Month, Day, Year) <b>8/13/2000</b>	
	29e. State Registrar <b>State Registrar</b>		29f. Registrar's Signature <i>[Signature]</i>		29g. License number <b>D0046345</b>		29h. Date signed (Month, Day, Year) <b>8/13/2000</b>	

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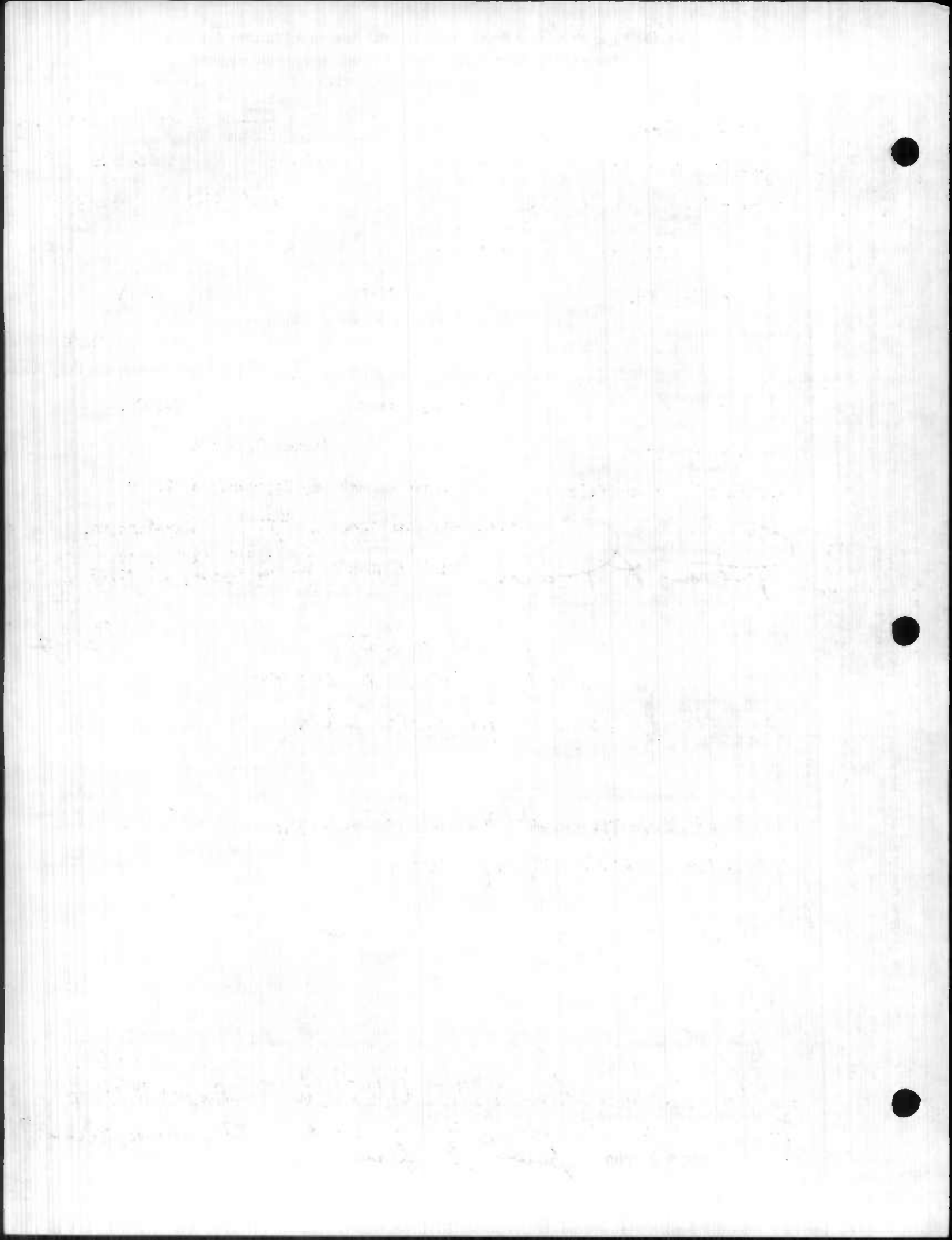
State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27710

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Edna Mae Wright</b>				2. Date of Death Month <b>August</b> Day <b>17</b> Year <b>2000</b>				3. Time of Death <b>1:05 P.M.</b>		
	4a. Facility Name (If not institution, give street and number) <b>Franklin Woods Center</b>				4b. City, Town, or Location of Death <b>Baltimore</b>				4c. County of Death <b>Baltimore</b>		
Funeral Director	5. Social Security Number <b>213-16-1460</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>78</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Jan. 25, 1922</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
	Usual Residence of Decedent										
10a. State <b>Md.</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number <b>949 Arnccliffe Rd.</b>				10f. Zip Code <b>21221</b>				10g. Citizen of What Country? <b>U.S.A</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> Collega (1-4or 5+) <b></b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Phone Operator</b>				16b. Kind of Business/Industry <b>Bus Co.</b>			
17. Father's Name (First, Middle, Last) <b>Harry D. Ferguson</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Hildred G. Smith</b>							
19a. Informant's Name/Relationship (Type, Print) <b>Patricia N. Brown (Friend)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1215 Windy Branch Way Edgewood, Md. 21040</b>							
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Smithsburg Crematory</b>		Data <b>Aug. 19 2000</b>		20c. Location - City or Town, State <b>Smithsburg, Md.</b>			
21. Signature of Funeral Service Licensee <b>J. Dennis L. Davis</b>				22. Name and Address of Facility <b>Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Md. 21783</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Urinary tract infection</b> Due to (or as a consequence of): <b>b. Indwelling Foley Catheter</b> Due to (or as a consequence of): <b>c. Stage 4 pressure ulcer</b> Due to (or as a consequence of): <b>d.</b>										Approximate Interval Between Onset and Death <b>7 days</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>s/p right kneereplacement (3/6/00), malnutrition anorexia, depression, s/p CVA</b>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner				29b. Signature and title of certifier <b>Thomas L. Edmonson MD</b>						29c. License number <b>D45766</b>	
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29a. Certifier (Check only one) 											



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27711

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Victor Enos Whitesel</b>					2. Date of Death Month Day Year <b>August 19, 2000</b>		3. Time of Death <b>10:45AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Fahrney-Keedy Nursing Home</b>					4b. City, Town, or Location of Death <b>Boonsboro</b>		4c. County of Death <b>Washington County</b>	
Funeral Director	5. Social Security Number <b>226-20-4648</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>97</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Feb. 28, 1903</b>		9. Birthplace (State or Foreign Country) <b>Virginia</b>
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>Washington Co.</b>		10c. City, Town or Location <b>Hagerstown</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>2042 Day Street</b>				10f. Zip Code <b>21740</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Professional Musician</b>				16b. Kind of Business/Industry <b>Musical Groups</b>		
	17. Father's Name (First, Middle, Last) <b>George E. Whitesel</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Coryetta May Collicho</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>V.L. Pat Paddack/Executor</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. Box 1825, Hagerstown, Maryland 21742</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Rest Haven Cemetery</b>		Date <b>Aug. 23</b>		20c. Location - City or Town, State <b>Hagerstown, Maryland</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Douglas A. Fiery Funeral Home 1331 Eastern Blvd., N., Hagerstown, Maryland 21742</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Lung cancer</b> Due to (or as a consequence of): <b>Metastatic lung cancer to liver</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>Chronic renal insufficiency</b> <b>Alzheimers</b>								Approximate Interval Between Onset and Death <b>2 years</b>
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic renal insufficiency</b> <b>Alzheimers</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>D0055926</b>		29d. Date signed (Month, Day, Year) <b>August 19, 2000</b>			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>William J. Hammerash, Jr., 100 Geeting Lane, Keedysville, Maryland 21756</b>									
31. Date filed (Month, Day, Year) <b>AUG 21 2000</b>		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27712

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>BARBARA A. ANDERSON</b>				2. Date of Death Month <b>AUGUST</b> Day <b>27</b> Year <b>2000</b>		3. Time of Death <b>0450</b>	
	4a. Facility Name (If not institution, give street and number) <b>UNIVERSITY OF MARYLAND HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>219-48-6934</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>56</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>FEB. 26, 1944</b>		9. Birthplace (State or Foreign Country) <b>SOUTH CAROLINA</b>
	Usual Residence of Decedent							
10a. State <b>MARYLAND</b>		10b. County <b>HOWARD</b>		10c. City, Town or Location <b>COLUMBIA</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>6345 GRAY SEA WAY</b>				10f. Zip Code <b>21045</b>		10g. Citizen of What Country? <b>USA.</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4 yrs</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>NURSE</b>		16b. Kind of Business/Industry <b>HOSPITAL</b>		
17. Father's Name (First, Middle, Last) <b>EDDIE MCCLAIN</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>JENSIS SAMUEL</b>				
19a. Informant's Name/Relationship (Type, Print) <b>TONITA ANDERSON (DAUGHTER)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6345 GRAY SEA WAY, COLUMBIA, MD. 21045</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ARBUTUS CEMETERY</b>		20c. Location - City or Town, State <b>9-01-00 BALTIMORE, MARYLAND</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE. BALTO. MD. 21217</b>				
23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Metastatic Lung Carcinoma</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HIV</b>								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number <b>P11616</b>		29d. Date signed (Month, Day, Year) <b>August 27, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>22 South Greene Street, Baltimore, Maryland 21201</b>								
31. Date filed (Month, Day, Year) <b>SEP 01 2000</b>				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

00 11 15

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27713

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Dorothy Andreassen

2. Date of Death  
Month Day Year

Aug. 31 2000

3. Time of Death

8 AM

4a. Facility Name (If not institution, give street and number)

ST. Agnes nursing home

4b. City, Town, or Location of Death

Ellicott City

4c. County of Death

Howard County

5. Social Security Number

056-10-6337

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

10/19/1913

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Columbia

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6056 Cedar Wood Drive

10f. Zip Code

21044-3699

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Trust Administrator

16b. Kind of Business/Industry

Midland Marine Bank

17. Father's Name (First, Middle, Last)

John Kenny

18. Mother's Name (First, Middle, Maiden Surname)

Agnes Riedy

19a. Informant's Name/Relationship (Type, Print)

Arthur Andreassen- Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6056 Cedar Wood Drive, Columbia, Maryland 21044-3699

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Johns' Cemetery

Date

9/5/2000

20c. Location - City or Town, State

New York

21. Signature of Funeral Service Licensee

Shirley L. Lemmer

MOU 741

22. Name and Address of Facility

Witzke Funeral Home,

5555 Twin Knolls Road, Columbia, Maryland 21045

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

CEREBRAL THROMBOSIS

a.

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician2 ☐ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Lasneem Salehmani

29c. License number

D28595

29d. Date signed (Month, Day, Year)

8/31/00

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

TASNEEM CARHANI, 7220 PARK HEIGHTS AVE BALTO MD

31. Date filed (Month, Day, Year)

SEP 01 2000

32. Registrar's Signature

B. Sparks

21208-

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

*[Faint, illegible handwritten text covering the majority of the page]*

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27714

Amended Item#19b per FHG787 9/21/2000 EW

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>VIRGIE B BALDRIDGE</b>				2. Date of Death Month <b>AUGUST</b> Day <b>30</b> Year <b>2000</b>		3. Time of Death <b>3:35 a.m.</b>
	4a. Facility Name (If not institution, give street and number) <b>FRANKLIN SQUARE HOSPITAL CENTER</b>				4b. City, Town, or Location of Death <b>ROSEDALE</b>		4c. County of Death <b>BALTIMORE</b>
Funeral Director	5. Social Security Number <b>236-38-6799</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>78</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Nov. 3 1921</b>	9. Birthplace (State or Foreign Country) <b>Kentucky</b>
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State <b>Md</b>	10b. County <b>Cecil</b>	10c. City, Town or Location <b>Colora</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>21 Pleasant Drive</b>			10f. Zip Code <b>21917</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>own home</b>		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Charles A Montgomery</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Ollie D Leadingham</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Claudia Baldridge/daughter</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21 Pleasant Drive Colora, Md 21917</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Holly Hill Cemetery</b>		Date <b>9/1/2000</b>		20c. Location - City or Town, State <b>Baltimore MD</b>
	21. Signature of Funeral Service Licensee <b>R. Terry Connelly</b>		22. Name and Address of Facility <b>Connelly Funeral Home of Essex 300 MACE AVE. Baltimore MD. 21221</b>				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>SEPSIS</b>						Approximate Interval Between Onset and Death
	Due to (or as a consequence of):						
	Due to (or as a consequence of):						
	Due to (or as a consequence of):						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>MYOCARDIAL INFARCTION</b> <b>CHRONIC RENAL FAILURE</b>							
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <b>Babak Immanuel DO</b>			29c. License number <b>H53939</b>		29d. Date signed (Month, Day, Year) <b>8/30/00</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Babak Immanuel, DO 9000 Franklin Square Dr. ; Baltimore, MD 21237-3958</b>							
31. Date filed (Month, Day, Year) <b>SEP 1 2000</b>		32. Registrar's Signature <b>[Signature]</b>					

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27715

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Lester S. Bellerive, Sr.					2. Date of Death Month: September Day: 01 Year: 2000		3. Time of Death 5:05AM			
	4a. Facility Name (If not institution, give street and number) Stella Maris					4b. City, Town, or Location of Death Timonium		4c. County of Death Baltimore			
Funeral Director	5. Social Security Number 041-05-9453		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 88 Yrs.		8. Date of Birth (Month, Day, Year) June 20 1912		9. Birthplace (State or Foreign Country) Connecticut		
	Usual Residence of Decedent										
10a. State Md.		10b. County Baltimore		10c. City, Town or Location Timonium				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 1 Sawgrass Ct.					10f. Zip Code 21093		10g. Citizen of What Country? USA				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 3 College (1-4 or 5+)					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Weaver			16b. Kind of Business/Industry Millwork			
17. Father's Name (First, Middle, Last) Albert Bellerive					18. Mother's Name (First, Middle, Maiden Surname) Mabel Wilson						
19a. Informant's Name/Relationship (Type, Print) Mrs. Patricia Coffey/Daughter					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 Sawgrass Ct. Timonium, Md. 21093						
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Service Co.		Date 9-02-00		20c. Location - City or Town, State Towson, Md.				
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204						
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>END STAGE DEMENTIA</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>HOSPICE</b>								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier 					29c. License number D43725		29d. Date signed (Month, Day, Year) 9/1/00				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093											
31. Date filed (Month, Day, Year) SEP 1 2000					32. Registrar's Signature 						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

SEPTEMBER 1, 2000 5:05 a.m.

Baltimore, Maryland 21215-0020

LESTER BELLERIVE

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 25a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27716

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN BARTLETT BROCK

2. Date of Death

Month Day Year  
August 29, 2000

3. Time of Death

10:27 PM

4a. Facility Name (If not institution, give street and number)

Greater Baltimore Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

233-34-1771

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Jan. 11, 1925

9. Birthplace (State or Foreign Country)

W. Va.

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Phoenix

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

14013 Jarrettsville Pike

10f. Zip Code

21131

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: WW-II

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Carpenter

16b. Kind of Business/Industry

Commercial

17. Father's Name (First, Middle, Last)

Charles

Brock

18. Mother's Name (First, Middle, Maiden Surname)

Mary

Snoderley

19a. Informant's Name/Relationship (Type, Print)

Mrs. Florence Brock/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14013 Jarrettsville Pike Phoenix, Md. 21131

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Dulaney Valley Memorial

Date

9/1/00

20c. Location - City or Town, State

Timonium, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.

1050 York Rd. Towson, Md. 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Lung Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 1/2 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Pulmonary Disease

Diabetes

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROBERT H WIDGESCO MD 3346 PAPERHILL Rd

PHOENIX Md 21131

31. Date filed (Month, Day, Year)

SEP 1 2000

32. Registrar's Signature

Benita B. Sparks

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27717

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Jane Eleanora Blake				2. Date of Death Month Day Year August 31, 2000				3. Time of Death 12:40 A.M.		
	4a. Facility Name (If not institution, give street and number) Gilchrist Center				4b. City, Town, or Location of Death Towson				4c. County of Death Baltimore Co.		
Funeral Director	5. Social Security Number 220-30-7306	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 66 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) June 16, 1934		9. Birthplace (State or Foreign Country) Baltimore, Maryland			
	Usual Residence of Decedent										
10a. State Maryland		10b. County Baltimore Co.		10c. City, Town or Location Baldwin				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 13600 Brookline Road				10f. Zip Code 21013		10g. Citizen of What Country? United States of America					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) n/a				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Home Maker			16b. Kind of Business/Industry Own Home				
17. Father's Name (First, Middle, Last) Herbert Lewis Rice				18. Mother's Name (First, Middle, Maiden Surname) Margaret Ethel Kropf							
19a. Informant's Name/Relationship (Type, Print) Mr. Paul R. Blake(Son)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13600 Brookline Road Baldwin, Maryland 21013							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Memorial Gardens			Date 9/02/2000		20c. Location - City or Town, State Timonium, Maryland		
21. Signature of Funeral Service Licensee Jeffrey L. Gair				22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204-2515							
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death	
Immediate Cause (Final disease or condition resulting in death) a. cerebral infarction										2 1/2 weeks	
Due to (or as a consequence of):											
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of):											
c. Due to (or as a consequence of):											
d. Due to (or as a consequence of):											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Small cell lung Cancer with Brain metastasis										23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										29b. Signature and title of certifier W.A. Riley, MD	
29c. License number D25205				29d. Date signed (Month, Day, Year) August 31, 2000							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W.A. Riley, MD 6701 N. Charles St. Balto. Md 21208											
31. Date filed (Month, Day, Year) SEP 1 2000				32. Registrar's Signature James G. Sparks							

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

BLAKE, JANE AUGUST 31, 2000 @ 12:40 AM  
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27718

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Thelma Estelle Bach</i>				2. Date of Death Month <i>August</i> Day <i>30</i> , Year <i>2000</i>		3. Time of Death <i>3:30 PM</i>	
	4a. Facility Name (If not institution, give street and number) <i>5109 Meridy Avenue</i>				4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>Baltimore</i>	
Funeral Director	5. Social Security Number <i>212-22-5429</i>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>73</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>July 28, 1927</i>	
	9. Birthplace (State or Foreign Country) <i>Maryland</i>		10a. State <i>Maryland</i>		10b. County <i>Baltimore</i>		10c. City, Town or Location <i>Baltimore</i>	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <i>5109 Meridy Avenue</i>		10f. Zip Code <i>21236</i>		10g. Citizen of What Country? <i>U.S.A.</i>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>White</i>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>6th Grade</i> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Cashier</i>		16b. Kind of Business/Industry <i>Grocery Store</i>			
	17. Father's Name (First, Middle, Last) <i>John Meyers</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Lillian Lance</i>		19a. Informant's Name/Relationship (Type, Print) <i>Mary L. Curzi (daughter)</i>			
To Be Completed by Physician/Medical Examiner	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>5109 Meridy Ave., Baltimore, MD 21236</i>		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Parkwood Cemetery</i>		20c. Location - City or Town, State <i>Baltimore, Maryland</i>	
	21. Signature of Funeral Service Licensee <i>Mark T. [Signature]</i>		22. Name and Address of Facility <i>Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236</i>					
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <i>Uremia</i> Due to (or as a consequence of): b. <i>Chronic Renal Failure</i> Due to (or as a consequence of): c. <i>Renal/Vascular Disease</i> Due to (or as a consequence of): d. <i>Hypertension</i>						Approximate Interval Between Onset and Death <i>7 days</i> <i>1 year</i> <i>2 years</i> <i>10 years</i>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>COPD</i>						23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>[Signature] MD</i>		29c. License number <i>D34124</i>		29d. Date signed (Month, Day, Year) <i>8-31-00</i>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>John D. M, Jr, MD 1205 York Rd #20 Lutherville, Md 21093</i>							
State Registrar	31. Date filed (Month, Day, Year) <i>SEP 1 2000</i>		32. Registrar's Signature <i>[Signature]</i>					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27719

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Viola Brown</b>				2. Date of Death Month <b>August</b> Day <b>28</b> Year <b>2000</b>				3. Time of Death <b>3:35 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Genesis Elder Care - Hunt House Center</b>				4b. City, Town, or Location of Death <b>Balto.</b>				4c. County of Death	
Funeral Director	5. Social Security Number <b>218-22-8890</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>89</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>6 2 1911</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent				10a. State <b>Maryland</b>				10b. County <b>Baltimore</b>	
To Be Completed by Funeral Director	10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number <b>1103 Tace Drive Apt 2C</b>	
	10f. Zip Code <b>21221</b>				10g. Citizen of What Country? <b>USA</b>				11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>				16b. Kind of Business/Industry <b>Domestic</b>	
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>William Biscoe</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>ELevyLine</b>				19a. Informant's Name/Relationship (Type, Print) <b>Grandson James E Brogden</b>	
	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1103 Tace Drive Apt 2C Balto. MD. 21221</b>				20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Voshell Cemetery</b>	
	20c. Location - City or Town, State <b>Balto. MD</b>				21. Signature of Funeral Service Licensee <b>[Signature]</b>				22. Name and Address of Facility <b>Miller Metropolitan Chapel P.C. 1639 N. Beardsbury Balto. MD.</b>	
	23a. Part I - Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>End stage Dementia</b>				Approximate Interval Between Onset and Death <b>5 yrs</b>					
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day, Year)				28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
State Registrar	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and Title of certifier <b>[Signature] Attending Physician</b>				29c. License number <b>D53642</b>	
	29d. Date signed (Month, Day, Year) <b>Aug 28 2000</b>				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>XERO 2HEOU 3007 E. Northern Parkway Baltimore 21214</b>					
	31. Date filed (Month, Day, Year) <b>SEP 1 2000</b>				32. Registrar's Signature <b>[Signature] B. Sparks</b>					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27720

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MAMIE BROOKS</b>				2. Date of Death Month Day Year <b>08 28 00</b>		3. Time of Death <b>11.25 am</b>	
	4a. Facility Name (If not institution, give street and number) <b>Genesis Elder Care</b>				4b. City, Town, or Location of Death <b>Randallstown</b>		4c. County of Death <b>Balto</b>	
Funeral Director	5. Social Security Number <b>217-22-1802</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>79</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>10-6-1920</b>	
	9. Birthplace (State or Foreign Country) <b>S.C.</b>		10a. State <b>Md</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Woodlawn</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number <b>6719 Windsor Mill Road</b>		10f. Zip Code <b>21207</b>	
	10g. Citizen of What Country? <b>U S A</b>				11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6th grade</b> College (1-4 or 5+) <b>N/A</b>	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homecare Provider</b>				16b. Kind of Business/Industry <b>Unk</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Vanderbelt Jones</b>				18. Mother's Name (First, Middle, Maiden Summa) <b>Lillian Roach</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Ernestine Holmes - Sister</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6719 Windsor Mill Road Baltimore, Md 21207</b>			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Garrison Forest Vet</b>		20c. Location - City or Town, State <b>9-1-00 Owings Mills, Md</b>	
	21. Signature of Funeral Service Licensee <b>John March</b>				22. Name and Address of Facility <b>March F/H West 4300 Wabash Avenue Baltimore, Md 21215</b>			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>HEPATIC CIRRHOSIS</b> Due to (or as a consequence of): <b>HEPATOMA</b> Due to (or as a consequence of): <b>HEPATITIS B</b> Due to (or as a consequence of):				Approximate Interval Between Onset and Death			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HYPERTENSION ; DIABETES ; PULMONARY EMBOLISM</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28d. Describe how injury occurred			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <b>W. Andrews</b>			
	29c. License number <b>DS2360</b>				29d. Date signed (Month, Day, Year) <b>8/28/00</b>			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>KULBIR SANDHU 1838 GREENE TREE RD SUITE 300 PICESVILLE MD 21208</b>				31. Data filed (Month, Day, Year) <b>SEP 1 2000</b>			
	32. Registrar's Signature <b>James B. Sparks</b>							





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 00 27721

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIAM

BUCHANAN

2. Date of Death

Month  
Aug.Day  
30Year  
2000

3. Time of Death

2:57 PM

4a. Facility Name (If not institution, give street and number)

Union Memorial Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

n/a

Funeral  
Director

5. Social Security Number

171-22-5409

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

73

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)

May 5

1927

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD

10b. County

n/a

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

4543 Schenley Rd.

10f. Zip Code

21210

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

n/a

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Manufacturing

16b. Kind of Business/Industry

Spice

17. Father's Name (First, Middle, Last)

James Buchanan

18. Mother's Name (First, Middle, Maiden Surname)

unk

19a. Informant's Name/Relationship (Type, Print)

William D. Buchanan/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8426 Miramar Rd., Apt. 10, Pasadena, MD 21122

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Chesapeake Crematory 9/1/00

Date

20c. Location - City or Town, State

Beltsville, MD

21. Signature of Funeral Director

Michael J. Hagle

22. Name and Address of Facility

Lemmon Funeral Home  
10 W. Padonia Rd., Timonium, MD 2109323a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

HYPOTERMIA

Due to (or as a consequence of):

RESPIRATORY FAILURE

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Due to (or as a consequence of):

COPD.

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29c. Signature and title of certifier

Rohit Guati, MD

29d. License number

D 51715

29e. Date signed (Month, Day, Year)

8/31/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROHIT GUATI, MD 5010 YORK ROAD BALTIMORE, MD 21212.

31. Date filed (Month, Day, Year)

SEP 1 2000

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
202-343-0000.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
certificate.

Page 1

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 27722

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MARJORIE A BINKEY</b>				2. Date of Death Month Day Year <b>AUGUST 25 2000</b>		3. Time of Death <b>10:15 PM</b>	
	4a. Facility Name (If not Institution, give street and number) <b>NORTH HAMPTON MANOR N.H.</b>				4b. City, Town, or Location of Death <b>FREDRICK, MD</b>		4c. County of Death <b>FREDRICK</b>	
Funeral Director	5. Social Security Number <b>186-32-4716</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>92</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>SEPT 30, 1908</b>	
	9. Birthplace (State or Foreign Country) <b>GREENSBURG PA</b>		10a. State <b>PA</b>		10b. County <b>INDIAN</b>		10c. City, Town or Location <b>HOMER CITY PA</b>	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>58 Miller Ave</b>		10f. Zip Code <b>19748</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>School Teacher</b>		16b. Kind of Business/Industry <b>EDUCATION</b>			
	17. Father's Name (First, Middle, Last) <b>BOYD L BINKEY</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>CORA STEEL BINKEY</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>CAROLYN A. DUBLE</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>24826-B PEN-MAR RD CASCADE MD 21719</b>			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>NEW ALEXANDRIA CEM</b>		20c. Location - City or Town, State <b>8/30/00 NEW ALEXANDRIA PA</b>		21. Signature of Funeral Service Licensee <b>Gray L Rollins</b>	
To Be Completed by Physician/Medical Examiner	22. Name and Address of Facility <b>Rollins F.H 11 South St Frederick MD</b>				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Sepsis</b>			
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			
To Be Completed by Physician/Medical Examiner	28a. Date of Injury (Month, Day, Year)				28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <b>[Signature]</b>		29c. License number <b>026499</b>	
	29d. Data signed (Month, Day, Year) <b>Aug 30, 2000</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DR RONALD MILLER 11 CUDLER RD MT AIRY MD 20876</b>					
To Be Completed by Physician/Medical Examiner	31. Date filed (Month, Day, Year) <b>SEP 1 2000</b>				32. Registrar's Signature <b>[Signature]</b>			
	33. Registrar's Name <b>[Signature]</b>							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

00 27723

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Gladys Bowie</i>				2. Date of Death Month <i>August</i> Day <i>24</i> Year <i>2000</i>				3. Time of Death <i>3 P.M.</i>										
	4a. Facility Name (If not institution, give street and number) <i>Long Green Genesis</i>				4b. City, Town, or Location of Death <i>Baltimore</i>				4c. County of Death <i>USA</i>										
Funeral Director	5. Social Security Number <i>218-14-4642</i>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>83</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>3/26/17</i>		9. Birthplace (State or Foreign Country) <i>Baltimore, Md.</i>										
	Usual Residence of Decedent																		
10a. State <i>Md.</i>		10b. County		10c. City, Town or Location <i>Baltimore</i>				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No											
10e. Street and Number <i>1422 Ward St.</i>				10f. Zip Code <i>21230</i>				10g. Citizen of What Country? <i>USA</i>											
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>											
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>College</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Homemaker</i>				16b. Kind of Business/Industry <i>Home</i>											
17. Father's Name (First, Middle, Last) <i>Augusta Robinson</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Edna Robinson</i>															
19a. Informant's Name/Relationship (Type, Print) <i>Charles Chesley Son</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1601 N. Payson St, Baltimore, Md. 21217</i>															
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Arbutus Mem. Park</i>			20c. Location - City or Town, State <i>8/30/00 Arbutus, Md.</i>													
21. Signature of Funeral Service Licensee <i>Sheryl M. Ester</i>				22. Name and Address of Facility <i>Estep Brothers Funeral Ser, P.A. 1300 Eutaw Place, Baltimore, Md. 21217</i>															
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																			
<table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td><i>Failure to Thrive</i></td> <td rowspan="4">           Approximate Interval Between Onset and Death             months             years             years         </td> </tr> <tr> <td>b.</td> <td><i>Dementia</i></td> </tr> <tr> <td>c.</td> <td><i>Diabetes Mellitus</i></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<i>Failure to Thrive</i>	Approximate Interval Between Onset and Death  months  years  years	b.	<i>Dementia</i>	c.	<i>Diabetes Mellitus</i>	d.	
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<i>Failure to Thrive</i>	Approximate Interval Between Onset and Death  months  years  years																
	b.	<i>Dementia</i>																	
	c.	<i>Diabetes Mellitus</i>																	
	d.																		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Carcinoma of Colon, Stroke</i>																			
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown																			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																			
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																			
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred										
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)												
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																			
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <i>D17118</i>				29d. Date signed (Month, Day, Year) <i>Aug 25, 2000</i>											
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Paul Schwartz MD 115 E. Melrose Ave 21212</i>																			
31. Date filed (Month, Day, Year) <i>SEP 1 2000</i>		32. Registrar's Signature <i>[Signature]</i>																	

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27724

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ARNETTA E CAMPBELL</b>				2. Date of Death Month <b>August</b> Day <b>29</b> Year <b>2000</b>		3. Time of Death <b>4:00 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>124 Academy Street</b>				4b. City, Town, or Location of Death <b>Cambridge</b>		4c. County of Death <b>Dorchester</b>	
Funeral Director	5. Social Security Number <b>218-48-1042</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>85</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>March 28, 1915</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>Dorchester</b>		10c. City, Town or Location <b>Cambridge</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>124 Academy Street</b>				10f. Zip Code <b>21613</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th</b> College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>own home</b>	
	17. Father's Name (First, Middle, Last) <b>Wilber Krauch</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Alice Sinclair</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Betty Perdue/daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9877 BirdRiver Road Baltimore MD 21220</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Zion Cemetery</b>		20c. Date <b>8/31/2000</b>		20d. Location - City or Town, State <b>Baltimore MD.</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Connelly Funeral Home of Essex 300 Mace Ave. Baltimore MD 21221</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. CARCINOMA OF LUNG METASTATIC 3 mm db.</b> Due to (or as a consequence of): <b>b. TO LIVER AND HUMBAR SPINE</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>							
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>POLYMYALGIA RHEUMATICA</b>							
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			
	28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
State Registrar	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier 				29c. License number <b>D 16609</b>		29d. Date signed (Month, Day, Year) <b>August 29, 2000</b>	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>MICHAEL A. MOSKIEWICZ MD 503 BLEN ST CAMBRIDGE MD</b>							
31. Date filed (Month, Day, Year) <b>SEP 1 2000</b>				32. Registrar's Signature 				



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State of Maryland / Department of Health and Mental Hygiene

00 27725

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Fredrica Clifton</b>				2. Date of Death Month <b>8</b> Day <b>29</b> Year <b>2000</b>		3. Time of Death <b>9:15 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>5974 Turnabout Lane Apt. #6</b>				4b. City, Town, or Location of Death <b>Columbia</b>		4c. County of Death <b>Howard</b>	
Funeral Director	5. Social Security Number <b>214-82-5714</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>39</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>4/25/1961</b>	
	9. Birthplace (State or Foreign Country) <b>Buffalo, N.Y.</b>		10a. State <b>MD</b>		10b. County <b>Howard</b>		10c. City, Town or Location <b>Columbia</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number <b>5974 Turnabout Lane Apt. #6</b>		10f. Zip Code <b>21044</b>	
	10g. Citizen of What Country? <b>USA</b>				11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>black</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>graphic artist</b>				16b. Kind of Business/Industry <b>Columbia Association</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Fred Clifton</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lucille (Sayles) Clifton</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Alexia Clifton- sister</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7441 Swan Point Way, Columbia, Md. 21045</b>			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Baltimore-Washington Crem</b>			
	20c. Location - City or Town, State <b>Laurel, MD.</b>				21. Signature of Funeral Service Licensee <b>Theresa L Lemmer</b>			
To Be Completed by Physician/Medical Examiner	22. Name and Address of Facility <b>Witzke Funeral Homes, Inc.</b>				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>ASTROCYTOMA</b>			
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			
To Be Completed by Physician/Medical Examiner	28a. Date of Injury (Month, Day, Year)				28b. Time of Injury <b>M</b>			
	28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28d. Describe how injury occurred			
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <b>Shanta Grossman MD</b>			
To Be Completed by Physician/Medical Examiner	29c. License number <b>D23683</b>				29d. Date signed (Month, Day, Year) <b>8/30/00</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>STANLEY A. GROSSMAN MD - Johns Hopkins Oncology Center</b>				31. Date filed (Month, Day, Year) <b>SEP 01 2000</b>			
To Be Completed by Physician/Medical Examiner	32. Registrar's Signature <b>B. Sparks</b>				33. Date of Death <b>8/29/2000</b>			
	34. State Registrar <b>SEP 01 2000</b>				35. Original			

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State of Maryland / Department of Health and Mental Hygiene

00 27726

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Susan Dement</b>				2. Date of Death Month <b>8</b> Day <b>24</b> Year <b>2000</b>		3. Time of Death <b>12:20 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Crofton Convalescent Home</b>				4b. City, Town, or Location of Death <b>Crofton</b>		4c. County of Death <b>Anne Arundel</b>	
Funeral Director	5. Social Security Number <b>221-14-4188</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>76</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>6/27/24</b>	
	9. Birthplace (State or Foreign Country) <b>Wash. D.C</b>		10a. State <b>MD</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Silver Springs</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>13200 Old Columbia Pike</b>		10f. Zip Code <b>20904</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify <b>white</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>home mailer</b>		16b. Kind of Business/Industry <b>own home</b>				
17. Father's Name (First, Middle, Last) <b>Henry Lank</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Blanche Hood</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Beverly Houser- daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2607 Conway Road, Odenton, Md. 21113</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Chesapeake Crem.</b>		20c. Location - City or Town, State <b>8/30/2000 Beltsville, Md</b>				
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Fleck's Funeral Home</b> <b>7601 Sandy Spring Road, Laurel, Md. 20707</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>Terminal Lung Cancer</b> Due to (or as a consequence of):  b. <b>Hypertensive Cardiovascular Disease</b> Due to (or as a consequence of):  c. <b>Pneumonia</b> Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death  Months  Years  Weeks						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Rakesh Arora, MD</b>		29c. License number <b>D20108</b>		29d. Date signed (Month, Day, Year) <b>8/31/00</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Rakesh Arora, MD 14300 Gallant Fox Ln., #222, Bowie, MD 20715</b>								
31. Date filed (Month, Day, Year) <b>SEP 01 2000</b>		32. Registrar's Signature 						

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.


00 27727

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

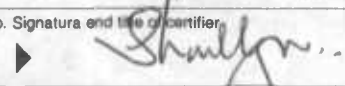

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) <b>MICHAEL EDWARDS</b>				2. Date of Death Month Day Year <b>AUGUST 30 2000</b>		3. Time of Death <b>3:19 AM</b>	
4a. Facility Name (If not institution, give street and number) <b>HARBOR HOSPITAL CENTER</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
5. Social Security Number <b>216-66-4401</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>44</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>2-3-56</b>	
9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Baltimore Highlands</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>3020 Ohio Ave.</b>		10f. Zip Code <b>21227</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Truck Driver</b>		16b. Kind of Business/Industry <b>Trucking</b>		17. Father's Name (First, Middle, Last) <b>David Lee Edwards</b>	
18. Mother's Name (First, Middle, Maiden Surname) <b>Marguerite C. Gayhardt</b>		19a. Informant's Name/Relationship (Type, Print) <b>Marguerite Lanasa, mother</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5170 76th St. North, St. Petersburg, FL. 33709</b>		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory</b>		20c. Location - City or Town, State <b>8-31-00 Catonsville, MD</b>		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD. 21227</b>	

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>GI BLEEDING</b> Due to (or as a consequence of): <b>END STAGE LIVER DISEASE</b> Due to (or as a consequence of): <b>CIRRHOSIS</b> Due to (or as a consequence of):				Approximate Interval Between Onset and Death <b>2 DAYS</b> <b>2 MONTHS</b> <b>1 YEAR</b>	
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HEPATITIS C</b> <b>ALCOHOLIC LIVER DISEASE</b>				23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day Year) <b>M</b>		28b. Time of injury <b>1</b> Yes <input type="checkbox"/> No <input type="checkbox"/> No	
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. Signature and title of certifier  <b>RESIDENT</b>		29c. License number <b>00055481</b>		29d. Date signed (Month, Day, Year) <b>AUGUST 30 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>SHWE MRA GYAW</b> <b>BALTIMORE MD 21225</b>		31. Data filed (Month, Day, Year) <b>SEP 1 2000</b>			
32. Registrar's Signature 				33. State Registrar <b>SEP 1 2000</b>	

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27728

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

William F. Giles

2. Date of Death

08

31

00

3. Time of Death

10:00 PM

4a. Facility Name (If not institution, give street and number)

Veteran's Administration Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore City

Funeral  
Director

5. Social Security Number

212-18-2579

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

79

8. Date of Birth (Month, Day, Year)

June 21, 1921

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore County

10c. City, Town or Location

English Council

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3900 Annapolis Rd.

10f. Zip Code

21227

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Transportation

17. Father's Name (First, Middle, Last)

William Giles

18. Mother's Name (First, Middle, Maiden Surname)

Lutie Johnson

19a. Informant's Name/Relationship (Type, Print)

Bertha E. Giles / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3900 Annapolis Rd., Baltimore, MD 21227

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery

Data

Sept 5

2000

20c. Location - City or Town, State

Brooklyn Park, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Kirkley-Ruddick Funeral Home, P.A.

421 Crain Hwy., S.E., Glen Burnie, MD 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

P12374

29d. Date signed (Month, Day, Year)

8/31/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

T. Burks, MD

Veteran's Administration Hospital 10 N. Greene St. Baltimore, MD

State  
Registrar

31. Date filed (Month, Day, Year)

SEP 1 2000

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27729

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Raymond Richard Gorski</b>				2. Date of Death Month Day Year <b>August 31, 2000</b>		3. Time of Death <b>10:30A</b>	
	4a. Facility Name (If not institution, give street and number) <b>FutureCare Facilities Canton Harbor</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>213-01-4815</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>95</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>July 12, 1905</b>	
	9. Birthplace (State or Foreign Country) <b>Poland</b>		10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>	
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>2723 Hudson Street</b>		10f. Zip Code <b>21224</b>		
10g. Citizen of What Country? <b>United States</b>		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Tool &amp; Die Maker</b>		16b. Kind of Business/Industry <b>Container Corporation</b>		
17. Father's Name (First, Middle, Last) <b>Franciszek Gorski</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Catherine Suckicha</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Marie Ann Leyko/ Niece</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2530 Rambling Court, Vienna VA 22181</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Holy Rosary Cemetery</b>		20c. Location - City or Town, State <b>9/2/00 Baltimore Maryland</b>		
21. Signature of Funeral Service Licensee <b>Kathleen Weber CFSP</b>				22. Name and Address of Facility <b>David J. Weber Funeral Homes, P.A. 401 S. Chester Street, Baltimore, Maryland 21231</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>CANCER OF LUNG</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):				Approximate Interval Between Onset and Death				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>COPD</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year) <b>10/1/00</b>		28b. Time of Injury <b>M</b>		
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <b>Campanella MD</b>		29c. License number <b>D16619</b>		
29d. Date signed (Month, Day, Year) <b>August 31, 2000</b>				30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>C. VERGARA-SOARES 1300 S. ELLWOOD AVE. BALTIMORE, MD 21224</b>				
31. Date filed (Month, Day, Year) <b>SEP 1 2000</b>				32. Registrar's Signature <b>Benita B. Spauls</b>				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

DHHM 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene

00 27730

Amended Item#20c perFHG787 9/21/2000 EW

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Anna Mary Gracey</b>				2. Date of Death Month <b>08</b> Day <b>25</b> Year <b>2000</b>		3. Time of Death <b>7:45PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Lorien Nursing Home</b>				4b. City, Town, or Location of Death <b>Columbia</b>		4c. County of Death <b>Howard</b>	
Funeral Director	5. Social Security Number <b>079-22-0293</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>80</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>Apr. 6, 1920</b>	9. Birthplace (State or Foreign Country) <b>Pa.</b>	
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>Howard</b>	10c. City, Town or Location <b>Columbia</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>6334 Cedar Lane</b>			10f. Zip Code <b>21044</b>		10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>nurse</b>		16b. Kind of Business/Industry <b>medical</b>			
	17. Father's Name (First, Middle, Last) <b>Lloyd Gracey</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Sukowski</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Helen E. Forbes/Friend</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7135 Smooth Path, Columbia, Md. 21045</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Oak Ridge Cemetery</b>		20c. Location - City or Town, State <b>Altoona, Penn</b>		20d. Date <b>9 /01/2000</b>	
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>Witzke Funeral Homes, Inc.</b> <b>555 Twin Knolls Road, Columbia, Md. 21045</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Metastatic Breast Cancer</b>							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred						
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <b>022567</b>		29d. Date signed (Month, Day, Year) <b>August 28 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Gary P. [unclear] 11055 Little Potomac Columbia, Maryland 21044</b>								
31. Date filed (Month, Day, Year) <b>SEP 01 2000</b>		32. Registrar's Signature <i>[Signature]</i>						

ORIGINAL

17. 11. 1950

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27731

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Kuth Hicks</b>				2. Date of Death Month <b>August</b> Day <b>30</b> Year <b>2000</b>		3. Time of Death <b>11:10pm.</b>	
	4a. Facility Name (If not institution, give street and number) <b>BON SECOURS HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>NIA</b>	
Funeral Director	5. Social Security Number <b>218-01-3514</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>90</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>SEPT. 09, 1909</b>	
	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>		10a. State <b>MARYLAND</b>		10b. County <b>NIA</b>		10c. City, Town or Location <b>BALTIMORE CITY</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>2027 N. DUKELAND STREET</b>		10f. Zip Code <b>21216</b>		10g. Citizen of What Country? <b>USA.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12<sup>th</sup> GRADE</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>BEAUTICIAN</b>		16b. Kind of Business/Industry <b>SELF-EMPLOYED</b>		17. Father's Name (First, Middle, Last) <b>WESLEY ROBINSON</b>	
	18. Mother's Name (First, Middle, Maiden Surname) <b>EDNA GROSS</b>		19e. Informant's Name/Relationship (Type, Print) <b>ALBERT L. HICKS JR. (SON)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1 MAIDSTONE CT. APT F, BALTIMORE, MD. 21237</b>		20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GARRISON FOREST</b>		20c. Location - City or Town, State <b>9-7-00 OWINGS MILLS, MD.</b>		21. Signature of Funeral Service Licenses <b>[Signature]</b>		22. Name and Address of Facility <b>JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTO. MD. 21217</b>	
	23e. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Pancreatic Carcinoma</b> Due to (or as a consequence of):  <b>b.</b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b>		Approximate Interval Between Onset and Death <b>3 months</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>[Signature] Medical House Officer</b>	
	29c. License number <b>1145148</b>		29d. Date signed (Month, Day, Year) <b>August, 30, 2000</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Ricardo Osorno, MD 2000 West Baltimore Street, Baltimore, Maryland 21223</b>		31. Date filed (Month, Day, Year) <b>SEP 01 2000</b>	
State Registrar	32. Registrar's Signature <b>[Signature]</b>		33. Registrar's Title <b>Registrar</b>		34. Registrar's Office <b>Baltimore</b>		35. Registrar's Phone <b>410-333-1234</b>	
	36. Registrar's Address <b>1000 North Enoch Avenue, Baltimore, MD 21201</b>		37. Registrar's Fax <b>410-333-1234</b>		38. Registrar's Email <b>registrar@dmh.state.md.us</b>		39. Registrar's Website <b>www.dmh.state.md.us</b>	

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020



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State of Maryland / Department of Health and Mental Hygiene

00 27732

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary Louise Heathington				2. Date of Death Month Day Year AUGUST 31 2000		3. Time of Death 2:10 A.M.
	4a. Facility Name (If not institution, give street and number) GOOD SAMARITAN HOSPITAL				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death BALTIMORE CITY
Funeral Director	5. Social Security Number 219-26-5190	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 61 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Oct. 13, 1938	9. Birthplace (State of Foreign Country) Maryland
	Usual Residence of Decedent						
10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number 3022 Chesterfield Avenue				10f. Zip Code 21213		10g. Citizen of What Country? U. S. A.	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 Years				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary		16b. Kind of Business/Industry Medical	
17. Father's Name (First, Middle, Last) Edward Steven Pietruszka				18. Mother's Name (First, Middle, Maiden Surname) Martha Genevieve Kolasinski			
19a. Informant's Name/Relationship (Type, Print) Charles R. Lutz (Companion)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3022 Chesterfield Avenue, Baltimore, Maryland 21213			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Green Mount Crematory		Data 9/5/00		20c. Location - City or Town, State Baltimore, Maryland	
21. Signature of Funeral Service Licensee Mark T. [Signature]				22. Name and Address of Facility Schimunek Funeral Home Inc. 3331 Brehms Lane, Baltimore, Maryland 21213			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CAD Due to (or as a consequence of): b. ASCVD Due to (or as a consequence of): c. RESPIRATORY FAILURE Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) —		28b. Time of Injury — M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) —				28d. Describe how injury occurred —			
28f. Location (Street and Number or Rural Route Number, City or Town, State) —							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier [Signature]				29c. License number D 18230		29d. Date signed (Month, Day, Year) AUGUST 31, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KALATHIL K. SHASHIDHARAN, M.D. 5601 LOCH RAVENBLVD BALTIMORE, MD 21239							
31. Date filed (Month, Day, Year) SEP 1 2000				32. Registrar's Signature [Signature]			

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27733

AMEND#9 PER F.H. G787 9-8-2000 JAB

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Hampton Harrell

2. Date of Death

Month Day Year  
August 29 2000 08:55 am

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

3509 Virginia Ave

4b. City, Town, or Location of Death

Baltimore, MD

4c. County of Death

Baltimore City

5. Social Security Number

249-40-6074

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

71

8. Date of Birth

Months Days

9. Birthplace (State or Foreign Country)

6-12-1929

10. Inside City Limits

☒ Yes ☐ No

Usual Residence of Decedent

10a. State

Md

10b. County

N/A

10c. City, Town or Location

Baltimore

10e. Street and Number

3509 Virginia Avenue

10f. Zip Code

21215

10g. Citizen of What Country?

U S A

11. Marital Status

☒ Never Married ☐ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
10th grade

College (1-4 or 5+)  
N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

work

16b. Kind of Business/Industry

work

17. Father's Name (First, Middle, Last)

Wiley Harrell

18. Mother's Name (First, Middle, Maiden Surname)

Martha Harrell

19a. Informant's Name/Relationship (Type, Print)

Frances H. Williams - Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

124 W. Franklin Street Apt 807 Balto, Md 21201

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Crownsville Veteran Cem

Date

9-1-00

20c. Location - City or Town, State

Crownsville, Md

21. Signature of Funeral Service Licensee

*Jerome A. Thompson*

22. Name and Address of Facility

March F/H West

4300 Wabash Avenue Baltimore, Md 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory Failure

Due to (or as a consequence of):

b. Chronic Obstructive Pulmonary Disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?  
☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient

☐ ER/Outpatient

☐ DOA

Other:

☐ Nursing Home

☒ Residence

☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Panding investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Delisle Sylvain*

29c. License number

051204

29d. Date signed (Month, Day, Year)

8/29/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Delisle Sylvain, 10 n. Greene st. Baltimore, MD 21201

31. Date filed (Month, Day, Year)

SEP 1 2000

32. Registrar's Signature

*James B. Sparks*

State  
Registrar

Harrell, Hampton ssn=249-40-6074  
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27734

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Leonard Hall</b>		2. Date of Death Month <b>August</b> Day <b>28</b> Year <b>2000</b>		3. Time of Death <b>1735</b>
	4a. Facility Name (If not institution, give street and number) <b>The Johns Hopkins Hospital</b>		4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>
Funeral Director	5. Social Security Number <b>213-32-1321</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>67</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>AUG. 7, 1933</b>	9. Birthplace (State or Foreign Country) <b>MD.</b>
	10a. State <b>MD.</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>
10e. Street and Number <b>26 S. PATTERSON PARK AVE.</b>			10f. Zip Code <b>21231</b>		10g. Citizen of What Country? <b>USA</b>
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>1952-1960</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>DOCK WORKER</b>	
16b. Kind of Business/Industry <b>TRUCKING</b>		17. Father's Name (First, Middle, Last) <b>UKN.</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>GENENA</b>	
19a. Informant's Name/Relationship (Type, Print) <b>CATHERINE BROCATO /FRIEND</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1629 ELRINO ST., BALTIMORE, MD. 21224</b>		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>CHESAPEAKE CREMATORY</b>		20c. Location - City or Town, State <b>8/31/00 BELTSVILLE, MD</b>	
21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <b>CHARLES S. ZEILER &amp; SON, INC. 6224 EASTERN AVE., BALTIMORE, MD. 21224</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Cirrhosis</b> Due to (or as a consequence of): <b>Acute Renal Failure</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>Diabetes</b>  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Gangrene</b> <b>Diabetes</b>					Approximate Interval Between Onset and Death <b>12 years</b> <b>2 1/2 weeks</b>
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>M</b>		28b. Time of Injury <b>1</b> Yes <b>2</b> No	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier <b>Katherine KChy MD</b>		29c. License number <b>RES 000</b>		29d. Date signed (Month, Day, Year) <b>August 28, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Katherine Chang 600 N. Wolfe St, Baltimore, MD 21210</b>					
31. Date filed (Month, Day, Year) <b>SEP 1 2000</b>		32. Registrar's Signature <i>[Signature]</i>			

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

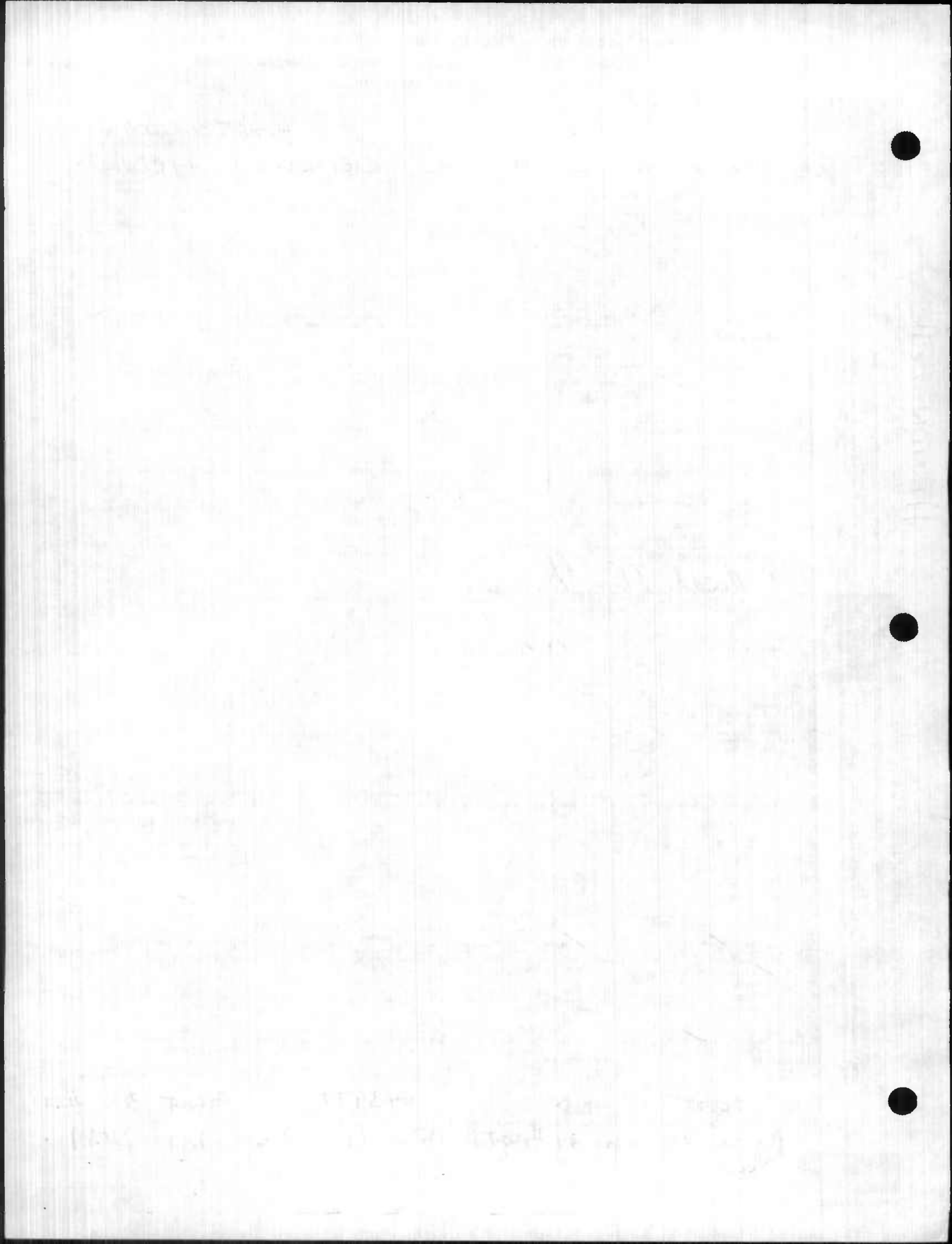
00 27735

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Belle Elizabeth Hinton				2. Date of Death Month Day Year AUGUST 30, 2000		3. Time of Death 1:35am	
	4a. Facility Name (If not institution, give street and number) NORTH ARUNDEL HOSPITAL				4b. City, Town, or Location of Death GLEN BURNIE		4c. County of Death AA COUNTY	
Funeral Director	5. Social Security Number 298-03-4220		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 94 Yrs.		8. Date of Birth (Month, Day, Year) October 12, 1905	
	9. Birthplace (State or Foreign Country) Illinois		10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Glen Burnie	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 8045 Winding Wood Road Apt. 11		10f. Zip Code 21061		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sales Clerk		16b. Kind of Business/Industry Retail Clothing			
	17. Father's Name (First, Middle, Last) George Charley		18. Mother's Name (First, Middle, Maiden Surname) Maude Leach		19a. Informant's Name/Relationship (Type, Print) Ray F. Hinton			
To Be Completed by Physician/Medical Examiner	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 47 Greenwood Shoals, Grasonville, MD 21638		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory Inc.		20c. Location - City or Town, State Baltimore, Maryland	
	21. Signature of Funeral Service Licensee Michael Stallings		22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Pneumonia Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):			
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			
To Be Completed by Physician/Medical Examiner	28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier MD		29c. License number D43977		29d. Date signed (Month, Day, Year) AUGUST 30 2000			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ayesha Durrani, 301 Hospital Drive, Glen Burnie, MD. 21061							
State Registrar	31. Date filed (Month, Day, Year) SEP 1 2000		32. Registrar's Signature Sparks					

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene

00 27736

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Richard W. Hamilton				2. Date of Death Month Day Year August 26, 2000		3. Time of Death 12:55 p.m.	
	4a. Facility Name (If not institution, give street and number) Franklin Square Hospital Center				4b. City, Town, or Location of Death Rosedale		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 213-26-7755		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 69 Yrs.		8. Date of Birth (Month, Day, Year) August 30, 1930	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Essex	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 513 Dorsey Avenue		10f. Zip Code 21221		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1948-1952		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Auto Assembler		16b. Kind of Business/Industry General Motors Co.				
17. Father's Name (First, Middle, Last) John O. Hamilton				18. Mother's Name (First, Middle, Maiden Surname) Emma M. Wolbert				
19a. Informant's Name/Relationship (Type, Print) Richard Hamilton (son)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 632 Kittendale Circle, Middle River, Maryland 21220				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens of Faith		20c. Location - City or Town, State Baltimore, Maryland		20d. Date 8/30/00		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Bruzdziński Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <u>Ventricular fibrillation</u> Due to (or as a consequence of): b. <u>atherosclerotic cardiovascular disease</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Diabetes type 2</u>								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier M.D.		29c. License number D10613		29d. Date signed (Month, Day, Year) 8-28-00				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAFAEL PEREZ-MERA 1777 REISTERSTOWN ROAD 21208								
31. Date filed (Month, Day, Year) SEP 1 2000		32. Registrar's Signature 						

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27737

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MARY LOUISE Iampieri</b>				2. Date of Death Month Day Year <b>August 27 2000</b>		3. Time of Death <b>8:00 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>8026 Forest Glen Drive</b>				4b. City, Town, or Location of Death <b>Pasadena</b>		4c. County of Death <b>Anne Arundel</b>		
Funeral Director	5. Social Security Number <b>212-36-2833</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>61</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>09/23/1938</b>		
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Pasadena</b>		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>8026 Forest Glen Drive</b>		10f. Zip Code <b>21122</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Domestic</b>		17. Father's Name (First, Middle, Last) <b>Thomas A. Lansinger</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Kathleen M. Rice</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Charles W. Iampieri / husband</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8026 Forest Glen Drive Pasadena, Maryland 21122</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Meadowridge Cemetery</b>		20c. Location - City or Town, State <b>Elkridge, Maryland</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>David J. Weber Funeral Homes, P.A. 5311 Edmondson Avenue Baltimore, Maryland 21229</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Lung Cancer</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate interval Between Onset and Death <b>3 years</b>			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>047137</b>		29d. Date signed (Month, Day, Year) <b>August, 28, 2000</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>PETER A. NAMINER MD 7845 OAKWOOD Rd GLENBURNIE, MD 21061</b>		31. Date filed (Month, Day, Year) <b>SEP 1 2000</b>		32. Registrar's Signature 					

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 27738

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Alice May Jones</b>				2. Date of Death Month <b>August</b> Day <b>29</b> Year <b>2000</b>				3. Time of Death <b>548 AM</b>				
	4a. Facility Name (If not institution, give street and number) <b>MARYLAND GENERAL HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE CITY</b>				4c. County of Death <b>N/A</b>				
Funeral Director	5. Social Security Number <b>217-12-9558</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>82</b> Yrs.		8. Date of Birth Month <b>Nov.</b> Day <b>25</b> Year <b>1917</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>				
	Usual Residence of Decedent				10a. State <b>Maryland</b>				10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>		
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number <b>4800 Seton Drive</b>				10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>African American</b>				
	15. Decedent's Education (Specify only highest grade completed) Elementary (Secondary (0-12)) <b>9</b> College (1-4or 5+)				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Daycare Provider</b>				16b. Kind of Business/Industry <b>Private</b>				
	17. Father's Name (First, Middle, Last) <b>Henry Morgan</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mabel Louise Wallace</b>								
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Mrs. Virginia Benton (daughter)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3912 Nemo Rd. Randallstown, Md. 21133</b>								
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arbutus Mem. Park</b>		20c. Location - City or Town, State <b>Balto. Md.</b>		20d. Date <b>9/5/2000</b>						
	21. Signature of Funeral Service licensee <b>Joseph L. Russ</b>				22. Name and Address of Facility <b>Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216</b>								
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				a. <b>Sepsis / Septicemia</b> Due to (or as a consequence of):								
				b. <b>Urinary Tract Infection</b> Due to (or as a consequence of):									
				c. Due to (or as a consequence of):									
				d. Due to (or as a consequence of):									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28e. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred			
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <b>Alan Rhoades M.D.</b>				29c. License number <b>89381</b>		29d. Date signed (Month, Day, Year) <b>8/29/00</b>			
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) <b>Alan Rhoades, M.D. to Maryland General Hospital.</b>													
31. Date filed (Month, Day, Year) <b>SEP 1 2000</b>				32. Registrar's Signature <b>[Signature]</b>									





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27739

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LILLIE MAE JONES</b>			2. Date of Death Month <b>August</b> Day <b>30</b> Year <b>2000</b>		3. Time of Death <b>7:06 A</b>	
	4a. Facility Name (If not institution, give street and number) <b>The Johns Hopkins Hospital</b>			4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>241-24-9517</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>94</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month <b>March</b> Day <b>6</b> Year <b>1906</b>	9. Birthplace (State or Foreign Country) <b>No. Carolina</b>
	Usual Residence of Decedent						
10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>1923 E. Baltimore Street</b>				10f. Zip Code <b>21231</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>American Indian</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11th</b> College (1-4or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Farmer</b>			16b. Kind of Business/Industry <b>Agriculture</b>	
17. Father's Name (First, Middle, Last) <b>Robert Locklear</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ada Chavis</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Victoria Jones/Granddaughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11917 Tarragon Rd. Reisterstown, MD 21136</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Oxendine Cemetery</b>		Date <b>9/2/00</b>		20c. Location - City or Town, State <b>Lumberton, No. Carolina</b>
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>David J. Weber Funeral Homes, P.A. 401 S. Chester St. Baltimore, Maryland 21231</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>PNEUMONIA</b> Due to (or as a consequence of):  b. <b>EMBOLIC CEREBRAL STROKE</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.							Approximate Interval Between Onset and Death  <b>4 DAYS</b>  <b>7 DAYS</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>NONE</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
				28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <b>M.D.</b>			29c. License number <b>RES-000</b>		29d. Date signed (Month, Day, Year) <b>August 30, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>BENJAMIN S. SHERMAN, M.D. 600 NORTH WOLFE STREET, BALTIMORE MD 21287</b>							
31. Date filed (Month, Day, Year) <b>SEP 1 2000</b>			32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified in writing.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27740

## Certificate of Death

Reg. No.

AMENDED ITEM #1 PER MD G787 9/1/00 AH

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

~~KAHIM~~

KAHIN

JOHNSON

2. Date of Death

Month  
Aug.Day  
18Year  
2000

3. Time of Death

6:55

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

University of Maryland Medical System

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

216-55-0606

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

1

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

6

26

1999

9. Birthplace (State or Foreign Country)

Md

Usual Residence of Decedent

10a. State

Md

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

1611 Bruce Court

10f. Zip Code

21217

10g. Citizen of What Country?

U S A

11. Marital Status

☒ Never Married ☐ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

N/A

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

N/A

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

Leonard White

18. Mother's Name (First, Middle, Maiden Surname)

Bonita Johnson

19a. Informant's Name/Relationship (Type, Print)

Bonita Johnson - Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1611 Bruce Court Apt 1 Baltimore, Md 21217

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

King Memorial Park

Date

8-21-00

20c. Location - City or Town, State

Randallstown, Md

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

March F/H West

4300 Wabash Avenue Baltimore, Md 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each lineImmediate Cause (Final  
disease or condition  
resulting in death)

Torsion II

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☐ No25. Was case referred to medical  
examiner?  
☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☒ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending  
investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicide ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician☐ Medical ExaminerTo the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Brian Boone MD

29c. License number

D32512

29d. Date signed (Month, Day, Year)

Aug 28, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BRIMAN J. BROWNE

University of Maryland Med. Center

22 South Greene St  
Baltimore Md 21201State  
Registrar

31. Date filed (Month, Day, Year)

SEP 1 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27741

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>EMMA JOHNSON</b>						2. Date of Death Month Day Year <b>AUGUST 29<sup>th</sup> 2000</b>		3. Time of Death <b>15:10</b>	
	4a. Facility Name (If not institution, give street and number) <b>Levidale Nursing Home</b>						4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death	
Funeral Director	5. Social Security Number <b>217-16-6805</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>91</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>12 30 08</b>		9. Birthplace (State or Foreign Country) <b>M.D.</b>	
	10a. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
To Be Completed by Funeral Director	10e. Street and Number <b>4226 Towanda Ave</b>						10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			
To Be Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th grade</b> College (1-4 or 5+) <b>na</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>House Wife</b>		16b. Kind of Business/Industry <b>Home</b>			
	17. Father's Name (First, Middle, Last) <b>Samuel Harris</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Madeline Ryan</b>			
To Be Completed by Funeral Director	19a. Informant's Name/Relationship (Type, Print) <b>Mary Hamilton-Niece</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4226 Towanda Ave, Baltimore Md 21215</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Western Star Cemetery</b>		20c. Location - City or Town, State <b>9/5/00 Baltimore Md</b>					
To Be Completed by Funeral Director	21. Signature of Funeral Service Licensee <i>Jerome A. Thompson</i>						22. Name and Address of Facility <b>March F/H West</b> <b>4300 Wabash Ave, Baltimore Md 21215</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. SEPSIS</b> Due to (or as a consequence of): <b>b. CORONARY ARTERY DISEASE</b> Due to (or as a consequence of): <b>c. SENILE DEMENTIA</b> Due to (or as a consequence of): <b>d.</b>						Approximate Interval Between Onset and Death <b>2 weeks</b> <b>10 YEARS</b> <b>2 YEARS</b>			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier <i>Hanna M. Evelyn M.D.</i>						29c. License number <b>D 54739</b>		29d. Date signed (Month, Day, Year) <b>August 29<sup>th</sup> 2000</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>2434 W. Belvedere Avenue, Baltimore Maryland 21215</b>									
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 1 2000</b>						32. Registrar's Signature <i>Sparks</i>			

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

amend item 1 per phys. G787 9/1/00 yf

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 27742

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LANERY JONES</b>				2. Date of Death Month Day Year <b>August 25, 2000</b>		3. Time of Death <b>10 59 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>STELLA MARIS Hospice</b>				4b. City, Town, or Location of Death <b>BALTO</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>219-10-7636</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>75</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>July 14, 1925</b>	9. Birthplace (State or Foreign Country) <b>S. C.</b>			
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>md.</b>	10b. County <b>N/A</b>	10c. City, Town or Location <b>BALTIMORE</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>524 CURLEY ST.</b>		10f. Zip Code <b>21205</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>657</b> College (1-4 or 5+) <b>N/A</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>CONSTRUCTION WORKER</b>		16b. Kind of Business/Industry <b>CONSTRUCTION CO.</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>JEFF JONES</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>LUCINDA JONES</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>DAISEY JEAN NIECE</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>615 DECKER AVE - BALTO, MD. 21205</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MT Zion Cemetery</b>		20c. Location - City or Town, State <b>8/30/00 LANSDBANE, MD.</b>			
	21. Signature of Funeral Service Licensee <b>Funeral Committee</b>			22. Name and Address of Facility <b>BETTS FUNERAL HOME 1129 N. CAROLINE ST - BALTO, MD 21213</b>				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Esophageal carcinoma</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d.</b>						Approximate Interval Between Onset and Death <b>3 months</b>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Cardiomyopathy</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>HOSPICE</b>					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
			28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
State Registrar	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier <b>Dr. [Signature]</b>		29c. License number <b>D40854</b>		29d. Date signed (Month, Day, Year) <b>August 28, 2000</b>			
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>DAVID RISEBERG 301 ST PAUL PI BALTIMORE MD 21202</b>							
	31. Date filed (Month, Day, Year) <b>SEP 1 2000</b>		32. Registrar's Signature <b>[Signature]</b>					

Baltimore, Maryland 21215-0020  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27743

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Herman Jackson				2. Date of Death Month Day Year August 29 2000		3. Time of Death 6:10 P.M.	
	4a. Facility Name (If not institution, give street and number) North Arundel Hospital				4b. City, Town, or Location of Death Glen Burnie		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 214-38-4506		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 59 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 27, 1940	
	9. Birthplace (State or Foreign Country) Virginia		10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Odenton	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 1261 Collins Avenue		10f. Zip Code 21113		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Logger		16b. Kind of Business/Industry Logging			
	17. Father's Name (First, Middle, Last) Drayton Alfred Jackson				18. Mother's Name (First, Middle, Maiden Surname) Polly McLaughlin			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Ruby Jackson (Wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1261 Collins Avenue, Odenton, MD 21113			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hillcrest Cemetery		Date 09/02 2000		20c. Location - City or Town, State Annapolis, MD	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Patricia J. [Signature]				22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. PULMONARY EMBOLISM Due to (or as a consequence of): b. STATUS POST RUPTURED VESSEL Due to (or as a consequence of): c. CHRONIC OBSTRUCTIVE LUNG DISEASE Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier [Signature] MD				29c. License number D43977		29d. Date signed (Month, Day, Year) August 29 2000	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cyrus Durrumji, 301 Hospital Drive, Glen Burnie, MD 21061							
State Registrar	31. Date filed (Month, Day, Year) SEP 1 2000				32. Registrar's Signature [Signature]			

ORIGINAL

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27744

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Edith Krollicki

2. Date of Death

August 24, 2000

3. Time of Death

12:00 PM

4a. Facility Name (If not institution, give street and number)

Laurel Regional Hospital

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Prince George

Funeral  
Director

5. Social Security Number

219-64-4362

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 17, 1913

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Columbia

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10140 WinterBrook Lane

10f. Zip Code

21045

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

James Newton Walker

18. Mother's Name (First, Middle, Maiden Surname)

Candace Jane (unknown)

19a. Informant's Name/Relationship (Type, Print)

Reba Haynes/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1102 11th Street Laurel Maryland 20707

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Baltimore/WashingtonCrematory 8/30/2000 Laurel, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

[Signature] MD1142

22. Name and Address of Facility

Fleck Funeral Home, Inc.

7601 Sandy Spring Rd., Laurel, Md. 20707

23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Malignant Arrhythmia  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

[Signature]

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of Certifier

[Signature]

29c. License number

D22856

29d. Date signed (Month, Day, Year)

August 24, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Brey I. Levine, MD 11055 Little Patuxent Pkwy, Columbia, MD 21044

31. Date filed (Month, Day, Year)

SEP 01 2000

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND#8 PER F.H. G787 9-1-2000 JAB

## Certificate of Death

Reg. No.

00 27745

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>THERESA KITTREDGE</b>		2. Date of Death Month Day Year <b>AUGUST 28 2000</b>		3. Time of Death <b>11:30 AM</b>
	4a. Facility Name (If not institution, give street and number) <b>GOOD SAMARITAN HOSPITAL</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>Baltimore City</b>
Funeral Director	5. Social Security Number <b>133-03-5017</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>89</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>Oct. 3, 1910</b>		9. Birthplace (State or Foreign Country) <b>New York</b>		
Usual Residence of Decedent					
10a. State <b>Maryland</b>		10b. County <b>Baltimore City</b>		10c. City, Town or Location <b>Baltimore City</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>5409 Creston Avenue</b>		10f. Zip Code <b>21214</b>	
10g. Citizen of What Country? <b>USA</b>		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) <b>6 yrs.</b>	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Clerk</b>		16b. Kind of Business/Industry <b>N. Y. State Labor Dept.</b>		17. Father's Name (First, Middle, Last) <b>John Joseph Ruff</b>	
18. Mother's Name (First, Middle, Maiden Surname) <b>Theresa Schoendorf</b>		19a. Informant's Name/Relationship (Type, Print) <b>Burton G. Aftanski</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5409 Creston Avenue Baltimore, Maryland 21214</b>	
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory Inc.</b>		20c. Location - City or Town, State <b>Baltimore, Md.</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death) <b>SEPSIS</b> Due to (or as a consequence of):					
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CONGESTIVE HEART FAILURE</b> <b>AORTIC STENOSIS</b> <b>CARDIO MYOPATHY</b>					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number <b>P 12555</b>		29d. Date signed (Month, Day, Year) <b>AUGUST 28, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>RAMIN ALTAH, MD 5601 LOGG RAVEN BOULEVARD, BALTIMORE, MD 21239</b>					
31. Date filed (Month, Day, Year) <b>SEP 1 2000</b>		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

A-14

DHMH 16 Rev 6/95

ORIGINAL



jhm

RICHARD B  
KESSLER

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State of Maryland / Department of Health and Mental Hygiene

28A-E PER MEO G787  
Certificate of Death

00 27746

Reg. No.

AMEND ITEMS: #23 PART I, 27,

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural" or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar  
DHHM 16 Rev 6/95

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>RICHARD KESSLER</b>		2. Date of Death Month Day Year <b>AUGUST 30, 2000</b>		3. Time of Death <b>00:50 AM</b>
	4a. Facility Name (If not institution, give street and number) <b>8014 VALLEY MANOR ROAD #1A</b>		4b. City, Town, or Location of Death <b>OWINGS MILLS</b>		4c. County of Death <b>BALTIMORE</b>
Funeral Director	5. Social Security Number <b>215-54-0303</b>	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>51</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>APR. 28, 1949</b>		9. Birthplace (State or Foreign Country) <b>MD</b>		
Usual Residence of Decedent					
10a. State <b>MD</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>OWINGS MILLS</b>	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
10e. Street and Number <b>8014 VALLEY MANOR ROAD #1A</b>			10f. Zip Code <b>21117</b>		10g. Citizen of What Country? <b>U.S.A.</b>
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>4</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>PAROLE OFFICER</b>		16b. Kind of Business/Industry <b>STATE OF MARYLAND</b>	
17. Father's Name (First, Middle, Last) <b>LEON KESSLER</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>ROSE BERER</b>		
19a. Informant's Name/Relationship (Type, Print) <b>EILEEN CAPLAN / SISTER</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6503 TROTWOOD COURT - BALTIMORE, MD 21209</b>		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ARLINGTON CHIZUK AMUNO</b>		Date <b>8/31/00</b>	20c. Location - City or Town, State <b>BALTIMORE, MD</b>
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>NARCOTIC INTOXICATION</b>					
Approximate Interval Between Onset and Death					
Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): a. _____ b. _____ c. _____ d. _____					
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last {					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b>			
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>Found: 8-30-00</b>		28b. Time of Injury <b>Found: 12:30</b>	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>UNKNOWN</b>			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>FOUND AT HOME</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>8014 VALLEY MANOR RD., OWINGS MILLS, MD</b>			
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number <b>OCME</b>		29d. Date signed (Month, Day, Year) <b>AUGUST 30, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201</b>					
31. Date filed (Month, Day, Year) <b>SEP 1 2000</b>		32. Registrar's Signature 			

ORIGINAL



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amend item 20b per fh G787 9/6/00 yf State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27747

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

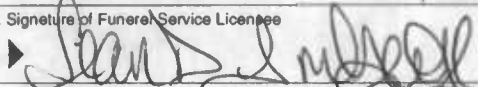
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Sophie Levin</b>		2. Date of Death Month <b>8</b> Day <b>30</b> Year <b>2000</b>		3. Time of Death <b>11:35 AM</b>	
4a. Facility Name (If not institution, give street and number) <b>Genesis Elder Care : Catonsville Commons</b>		4b. City, Town, or Location of Death <b>Catonsville</b>		4c. County of Death <b>Baltimore</b>	
5. Social Security Number <b>217-58-0271</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>79</b> Yrs.	8. Date of Birth <b>02/22/1921</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	
Usual Residence of Decedent					
10a. State <b>MD</b>	10b. County <b>Baltimore</b>	10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>939 Elmridge Ave.</b>		10f. Zip Code <b>21227</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give X Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>	
16b. Kind of Business/Industry <b>Own Home</b>		17. Father's Name (First, Middle, Last) <b>Louis Schlisler</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Martha Hinkel</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Paul Levin / son</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>939 Elmridge Ave. Baltimore, Maryland 21227</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Moreland Memorial Park</b>		20c. Location - City or Town, State <b>01 09/30/00 Parkville, Maryland</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, Maryland 21227</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Metastatic Brain Cancer</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. _____</b> Due to (or as a consequence of): <b>c. _____</b> Due to (or as a consequence of): <b>d. _____</b>					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Cerebrovascular Accident</b> <b>Alzheimer's Dementia</b>					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. Signature and title of certifier  MD		29c. License number <b>DS2671</b>		29d. Date signed (Month, Day, Year) <b>August 30, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Shalini Tewari M.D. 1838 Greene Tree Road / Suite 300 / Pikesville, MD 21208</b>					
31. Date filed (Month, Day, Year) <b>SEP 1 2000</b>		32. Registrar's Signature 			

ORIGINAL





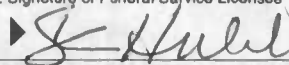
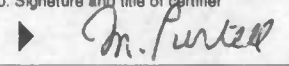

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27748

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>William Frederick Liebig</u>				2. Date of Death Month <u>August</u> Day <u>30</u> Year <u>2000</u>		3. Time of Death <u>8:23 pm</u>	
	4a. Facility Name (If not institution, give street and number) <u>1322 Broening Hwy</u>				4b. City, Town, or Location of Death <u>Baltimore</u>		4c. County of Death <u>N/A</u>	
Funeral Director	5. Social Security Number <u>213-05-1422</u>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <u>86</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>April 21, 1914</u>	
	9. Birthplace (State or Foreign Country) <u>Maryland</u>		10a. State <u>MD</u>		10b. County <u>N/A</u>		10c. City, Town or Location <u>Baltimore</u>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number <u>1322 Broening Hwy</u>		10f. Zip Code <u>21224</u>	
	10g. Citizen of What Country? <u>United States</u>				11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <u>white</u>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>6</u> College (1-4 or 5+) <u>College</u>	
	16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Manager</u>				16b. Kind of Business/Industry <u>Movie Theater</u>		17. Father's Name (First, Middle, Last) <u>John A. Liebig</u>	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) <u>Annie F. Nolte</u>				19a. Informant's Name/Relationship (Type, Print) <u>Kathleen Mattox / daughter</u>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1703 Leslie Rd Baltimore, MD 21222</u>	
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Chesapeake Crematory, Inc</u>		20c. Date <u>9/1/00</u>	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <u>CAFA Stephen D. Lohrmann, P.A.</u> <u>8717 Green Pastures Dr., Towson, MD 21286</u>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <u>PANCREATIC CANCER</u> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):				Approximate Interval Between Onset and Death <u>1 MONTH</u>			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year) <u>8/31/00</u>			
To Be Completed by Physician/Medical Examiner	28b. Time of Injury <u>M</u>				28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
To Be Completed by Physician/Medical Examiner	28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
	29b. Signature and title of certifier  <u>Dr. Purcell Staff Physician</u>				29c. License number <u>019714</u>			
To Be Completed by Physician/Medical Examiner	29d. Date signed (Month, Day, Year) <u>8/31/00</u>				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>MICHAEL PURTELL, JYBVMC 4140 EAGLE AVE, BALTIMORE, MD 21224</u>			
	31. Date filed (Month, Day, Year) <u>SEP 1 2000</u>				32. Registrar's Signature 			



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27749

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Gertrude Ethel McDermott				2. Date of Death Month Day Year August 29 2000		3. Time of Death 3:50 PM		
	4a. Facility Name (If not institution, give street and number) Charlestown Care Center				4b. City, Town, or Location of Death Catonsville		4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 129.34.5711		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) June 23, 1910		
	9. Birthplace (State or Foreign Country) New York								
Usual Residence of Decedent									
10a. State MD		10b. County Baltimore		10c. City, Town or Location Catonsville			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 715 Maiden Choice Lane				10f. Zip Code 21228		10g. Citizen of What Country? U.S.A.			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bookkeeper		16b. Kind of Business/Industry Plumbing & Heating			
17. Father's Name (First, Middle, Last) Harry Ferris				18. Mother's Name (First, Middle, Maiden Surname) Wilhelmina Todd					
19a. Informant's Name/Relationship (Type, Print) James McDermott/ Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12303 Mount Pleasant Dr. Laurel, Md. 20708					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mount St. Marys Cem.		Date 9/5		20c. Location - City or Town, State Flushing, New York			
21. Signature of Funeral Service Licensee [Signature]				22. Name and Address of Facility Fleck Funeral Home 7601 Sandy Spring Road Laurel, Md. 20707					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Lower Gastrointestinal Bleeding Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) as stated.									
29b. Signature and title of certifier [Signature] MD				29c. License number D34053		29d. Date signed (Month, Day, Year) August 29, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gary Applebaum MD 711 Maiden Choice Lane 21228									
31. Date filed (Month, Day, Year) SEP 01 2000				32. Registrar's Signature [Signature]					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#8 per FHG787 9/20/2000 EW

## Certificate of Death

Reg. No.

00 27750

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JACK MCKAY</b>				2. Date of Death Month <b>8</b> Day <b>28</b> Year <b>2000</b>		3. Time of Death <b>22.00</b>
	4a. Facility Name (If not institution, give street and number) <b>Laurel Regional Hospital</b>				4b. City, Town, or Location of Death <b>Laurel</b>		4c. County of Death <b>Prince George's</b>
Funeral Director	5. Social Security Number <b>379-20-0263</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>74</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>4-14-26</b> <b>APR. 24, 1926</b>	9. Birthplace (State or Foreign Country) <b>Indiana</b>
	Usual Residence of Decedent						
10a. State <b>MD</b>		10b. County <b>Prince George</b>		10c. City, Town or Location <b>Laurel</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>15311 Bond Mill Rd.</b>				10f. Zip Code <b>20707</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Analyst</b>		16b. Kind of Business/Industry <b>U. S. Government</b>			
17. Father's Name (First, Middle, Last) <b>Charles McKay</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mildred Armstrong</b>			
19a. Informant's Name/Relationship (Type, Print) <b>John Pickett - son-in-law</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>15311 Bond Mill Rd., Laurel, Md. 20707</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Baltimore Washington Crm.</b>		Date <b>8/31/00</b>		20c. Location - City or Town, State <b>Laurel, Md.</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Fleck Funeral Home</b> <b>7601 Sandy Spring Rd., Laurel, Md. 20707</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Acute Myocardial Infarction</b> Due to (or as a consequence of): <b>b. Generalized Arteriosclerosis</b> Due to (or as a consequence of): <b>c. Diabetes Mellitus</b> Due to (or as a consequence of): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred	
		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier  Physician					
		29c. License number <b>208307</b>		29d. Date signed (Month, Day, Year) <b>8/29/00</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DR TAYLOR MOURTZANAKIS 3470 Fort Meade Rd, Suite 109, Laurel, MD 20724</b>							
31. Date filed (Month, Day, Year) <b>SEP 01 2000</b>		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





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State of Maryland / Department of Health and Mental Hygiene 00 27751

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John Leo Mohl				2. Date of Death Month Day Year August 25, 2000				3. Time of Death 8:34am				
	4a. Facility Name (If not institution, give street and number) 2813 Frederick Rd.				4b. City, Town, or Location of Death Baltimore				4c. County of Death N/A				
Funeral Director	5. Social Security Number 217-40-0116		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 57 Yrs.		If Under 1 Year Months Days		8. Date of Birth (Month, Day, Year) 11-16-1942		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent												
10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number 2512 Dulaney St.				10f. Zip Code 21223				10g. Citizen of What Country? U.S.A.					
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 10				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Machinist				16b. Kind of Business/Industry Shipping					
17. Father's Name (First, Middle, Last) Charles Walter Mohl						18. Mother's Name (First, Middle, Maiden Surname) Blanche Isabelle Gowran							
19a. Informant's Name/Relationship (Type, Print) Charles E. Mohl, brother						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2517 Dulaney St. Baltimore, MD. 21223							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) MD Veterans Cemetery, Garrison Forest				Date 8-28-00		20c. Location - City or Town, State Owings Mills, MD			
21. Signature of Funeral Service Licensee [Signature]				22. Name and Address of Facility Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Rd. Lansdowne, MD. 21227									
23a. Part I - Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Lung Cancer Due to (or as a consequence of):  b. Chronic Obstructive Pulmonary Disease Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Squamous Cell Carcinoma of the Larynx										23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
										24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) friend's home									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of injury (Month, Day Year)		28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
29b. Signature and title of certifier [Signature] NADA KIWAN, M.D.						29c. License number D0040783			29d. Date signed (Month, Day, Year) August 29, 2000				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) NADA KIWAN, M.D. BALTIMORE VA MED CTR. 10 NORTH GREEKE ST. BALTIMORE, MD. 21201													
31. Date filed (Month, Day, Year) SEP 1 2000				32. Registrar's Signature [Signature]									

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

00 27752

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Norma K. Marshall				2. Date of Death Month Day Year AUGUST 28, 2000				3. Time of Death 5:20AM		
	4a. Facility Name (If not institution, give street and number) GREATER BALTIMORE MEDICAL CENTER				4b. City, Town, or Location of Death TOWSON				4c. County of Death BALTIMORE		
Funeral Director	5. Social Security Number 216-12-7527		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 5, 1920		9. Birthplace (State or Foreign Country) Maryland		
	10a. State MD				10b. County Baltimore		10c. City, Town or Location Woodlawn				
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 3509 Abbie Place				10f. Zip Code 21244		10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Own Home			
17. Father's Name (First, Middle, Last) George Kuhn				18. Mother's Name (First, Middle, Maiden Surname) Sophia Chetalat							
19a. Informant's Name/Relationship (Type, Print) Judith Marshall Feeney-Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21327 Gunpowder Road Manchester, Maryland 21101							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest				20c. Location - City or Town, State 9/1/00 Owings Mills, Maryland			
21. Signature of Funeral Service Licensee Joseph J. Kellerer				22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 8728 Liberty Road, Randallstown, MD 21133							
23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic breast carcinoma Due to (or as a consequence of): b. Sepsis Due to (or as a consequence of): c. Pneumonia Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death one year one week			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of injury (Month, Day Year)		28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Marshall A. Levine, M.D.				29c. License number D17873		29d. Date signed (Month, Day, Year) August 29, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marshall A. Levine, M.D. 6569 North Charles				Towson, MD 21204							
31. Date filed (Month, Day, Year) SEP 1 2000				32. Registrar's Signature B Sparks							

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

00 27753

amend item 8 per fh G787 9/1/00 yf

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Henry Wells Morris Sr.						2. Date of Death Month Day Year August 29, 2000		3. Time of Death 11:30 AM	
	4a. Facility Name (If not institution, give street and number) 1357 Halstead Road						4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 213-07-7335		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 85 Yrs.		8. Date of Birth (Month, Day, Year) 7/2/1915		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
10a. State MD		10b. County Baltimore		10c. City, Town or Location Baltimore				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 1357 Halstead Road				10f. Zip Code 21234		10g. Citizen of What Country? U.S.A.				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher			16b. Kind of Business/Industry Baltimore City			
17. Father's Name (First, Middle, Last) Henry W. Morris						18. Mother's Name (First, Middle, Maiden Surname) Lelia James				
19a. Informant's Name/Relationship (Type, Print) Victoria L. Morris/Daughter						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3213 Juneau Place Baltimore, Maryland 21214				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory		Date 9/1/00		20c. Location - City or Town, State Laurel, Maryland			
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Acute myocardial infarction Due to (or as a consequence of): b. Coronary Artery Disease Due to (or as a consequence of): c. Hyperlipidemia Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death Minutes years years	
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension Peripheral vascular Disease								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier Dr. Angelos C. Lymos MD		29c. License number D19589		29d. Date signed (Month, Day, Year) 8-31-00			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7801 YORK Rd Towson MD 21204										
31. Date filed (Month, Day, Year) SEP 1 2000			32. Registrar's Signature Benjamin P. Sparks							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27754

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIE E. MILLEDGE

2. Date of Death

August 28, 2000 2:00 am

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Maryland General Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

5. Social Security Number

212-46-2369

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

55 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

05-05-45

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

807 N. CAREY STREET

10f. Zip Code

21217

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: BLACK

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12 TH GRADE

2 YRS

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

COUNSELOR

16b. Kind of Business/Industry

DEPT. OF RECREATION

17. Father's Name (First, Middle, Last)

CHARLIE MILLEDGE

18. Mother's Name (First, Middle, Maiden Surname)

CARLETHA RAYNOR

19a. Informant's Name/Relationship (Type, Print)

HAROLD MILLEDGE BROTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1004 W. 42<sup>ND</sup> STREET, BALTO. MD. 21211

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

BARRISON FOREST

Date

9-1-00

20c. Location - City or Town, State

OWINGS MILLS, MD

21. Signature of Funeral Service Licensee

Vaughn C. Greene

22. Name and Address of Facility

VAUGHN C. GREENE FUNERAL SERVICE  
5151 BALTO. NATL PIKE, BALTO. MD. 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)

a. Sepsis

Due to (or as a consequence of):

b. Pneumonia

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

c.

Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pancreatitis, Severe Malnutrition, macrocytic,  
Anemia, Liver Failure, Thrombocytopenia,  
Alcohol Use

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Vaughn C. Greene, MD

29c. License number

89344

29d. Date signed (Month, Day, Year)

8/28/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John Adams, M.D. 90 Maryland General Hospital

31. Date filed (Month, Day, Year)

SEP 1 2000

32. Registrar's Signature

P. Sparks

State  
Registrar

ORIGINAL

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27755

## Certificate of Death

Reg. No.

EMMA

McGINNISS

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

EMMA A. MCGINNISS

2. Date of Death

Month Day Year  
AUGUST 30, 2000

3. Time of Death

8:26P.M.

4a. Facility Name (If not institution, give street and number)

323 S. CASTLE STREET

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

217-16-8351

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
March 28, 1924

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

323 S. CASTLE STREET

10f. Zip Code

21231

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify:

WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

HOUSEWIFE

16b. Kind of Business/Industry

DOMESTIC

17. Father's Name (First, Middle, Last)

UNKNOWN SCHMIDT

18. Mother's Name (First, Middle, Maiden Surname)

UNKNOWN

19a. Informant's Name/Relationship (Type, Print)

CHARLES MCGINNISS, SR. / SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

25 LEXINGTON ROAD, HARMANS, MARYLAND 21077

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

OAK LAWN CEMETERY

Date

9/2/00

20c. Location - City or Town, State

BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee

▶

22. Name and Address of Facility

LILLY &amp; ZEILER INC. FUNERAL HOME

1901 EASTERN AVENUE, BALTIMORE, MARYLAND 21231

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

Hypertensive Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?  
INSPECTION1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

SCENE

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending  
investigation6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

▶

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

AUGUST 31, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. Laron Locke M.D.

111 Penn Street, Baltimore, Maryland 21201

State  
Registrar

31. Date filed (Month, Day, Year)

SEP 1 2000

32. Registrar's Signature

▶

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural," or items 23a or 23e-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

*[Faint, illegible handwritten text]*

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27756

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

CHARLES HENRY NEWMAN

2. Date of Death

August 26 2000 2:45 AM

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Bayview Geriatrics Center Baltimore

4b. City, Town, or Location of Death

4c. County of Death

N/A

5. Social Security Number

218-12-4859

6. Sex

M ☒ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

AUG 25, 1914

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

272 EAST AVENUE

10f. Zip Code

21231

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
6TH GRADE

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

LABORER

16b. Kind of Business/Industry

SELF-EMPLOYED

17. Father's Name (First, Middle, Last)

WALTER

18. Mother's Name (First, Middle, Maiden Surname)

SALLY EMMA THOMPSON

19a. Informant's Name/Relationship (Type, Print)

CHARLES OWENS (NEPHEW)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4113 RIDGEWOOD AVENUE BALTO. MD.

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ARBUTUS CEMETERY

Date

9-01-00 BALTIMORE, MARYLAND

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

JOSEPH H. BROWN JR. FUNERAL HOME  
2140 N. FULTON AVE. BALTIMORE, MD. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cerebrovascular Accident - recurrent

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HTN, Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D45757

29d. Date signed (Month, Day, Year)

August 28, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MATTHEW MCNABNEY 5505 HOPKINS Bayview Circle BALTO 21224

31. Date filed (Month, Day, Year)

SEP 01 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transfer

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27757

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Teresa Repetti, S.N.D.de Namur				2. Date of Death Month Day Year August 30 2000		3. Time of Death 6:20 pm		
	4a. Facility Name (If not institution, give street and number) Stella Maris				4b. City, Town, or Location of Death Timonium		4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 207-40-0575	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Jan 30, 1913		9. Birthplace (State or Foreign Country) Washington, DC	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State MD	10b. County Baltimore	10c. City, Town or Location Stevenson			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number 1531 Greenspring Valley Road				10f. Zip Code 21153		10g. Citizen of What Country? United States		
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+		18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher		16b. Kind of Business/Industry Catholic High School				
	17. Father's Name (First, Middle, Last) Clarence Leo Repetti				18. Mother's Name (First, Middle, Maiden Surname) Edna Elinor Freeman				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Sr. Joan Maureen/Administrator				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1531 Greenspring Valley Road Stevenson, MD 21153				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Ilchester Cemetery		Date 09/02/00		20c. Location - City or Town, State Ellicott City, MD		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Ruck Towson Funeral Home, Inc 1050 York Road Towson, Maryland 21204				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CHRONIC LYMPHATIC LEUKEMIA Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D 15504		29d. Date signed (Month, Day, Year) 30 Aug 00			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eddie Nakhuda, M.D. 2300 Dulaney Valley Rd Timonium, Md 21093									
31. Date filed (Month, Day, Year) SEP 1 2000		32. Registrar's Signature 							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27758

amended item #20b per fh g787 9/6/00 ah

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Helen J. Neails</b>		2. Date of Death Month <b>August</b> Day <b>29</b> Year <b>2000</b>		3. Time of Death <b>12:40pm</b>
	4a. Facility Name (If not institution, give street and number) <b>Blue Point Nursing Home</b>		4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death
Funeral Director	5. Social Security Number <b>229-28-4623</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>73</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>07 15 27</b>		9. Birthplace (State or Foreign Country) <b>V.A.</b>		
Usual Residence of Decedent					
10a. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number <b>2918 Boarman Ave</b>			10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>U.S.A.</b>
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th grade</b>		College (1-4 or 5+) <b>na</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>House Keeper</b>	
16b. Kind of Business/Industry <b>Private</b>					
17. Father's Name (First, Middle, Last) <b>Nat Reed</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Mable</b>		
19a. Informant's Name/Relationship (Type, Print) <b>James Neail-Husband</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2918 Boarman Ave, Baltimore Md 21215</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Garrison Forest Vet.</b>		20c. Location - City or Town, State <b>Owings Mills, Md</b>	
21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <b>March F/H West</b> <b>4300 Wabash Ave, Baltimore Md 21215</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Cerebral Vascular accident</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>Unborn</b> Due to (or as a consequence of):  <b>Hypertension</b> <b>Dementia</b> Due to (or as a consequence of):  <b>23b. Did tobacco use contribute to the cause of death?</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  <b>24a. Was an autopsy performed?</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  <b>24b. Were autopsy findings available prior to completion of cause of death?</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension</b> <b>Dementia</b>					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <i>[Signature]</i> MD		29c. License number <b>D27564</b>		29d. Date signed (Month, Day, Year) <b>09/30/00</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Allen Kettlemann 1838 Greene Tree Rd #300</b>					
31. Date filed (Month, Day, Year) <b>SEP 1 2000</b>		32. Registrar's Signature <i>[Signature]</i>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-534-2000.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27759

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Lucille Emma Nelson

2. Date of Death

August 22, 2000

3. Time of Death

10:22 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

SINAI HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

NA

5. Social Security Number

215-16-7595

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug 29 1917

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3712 CHATHAM ROAD

10f. Zip Code

21216

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

NA

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Manager

16b. Kind of Business/Industry

Theater Westinghouse

17. Father's Name (First, Middle, Last)

William H. Lomax

18. Mother's Name (First, Middle, Maiden Surname)

Lucille Olive

19a. Informant's Name/Relationship (Type, Print)

Gwendolyn Douglass-Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12 Hobart Ct. Balto Md. 21133

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arbutus Mem. Park

Date

9-1-00

20c. Location - City or Town, State

Balto Md

21. Signature of Funeral Service Licensee

Gale March

22. Name and Address of Facility

March Funeral Home West, Inc

4300 Wabash Ave. Balto Md 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction

Due to (or as a consequence of)

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Coronary artery disease

Due to (or as a consequence of)

c. Hypertension

Due to (or as a consequence of)

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

diabetes mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

D.O.

29c. License number

RES 000

29d. Date signed (Month, Day, Year)

August 22 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JEREMY GRAYM DO 7401 W BELVEDERE AVE, BALTIMORE, MD

31. Date filed (Month, Day, Year)

1 2000

32. Registrar's Signature

A. Sparks

State  
Registrar

Patient known as: Nelson, Lucille Emma

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27760

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>OWENS</i>		2. Date of Death Month <i>August</i> Day <i>29</i> Year <i>2000</i>		3. Time of Death <i>12:50 PM</i>
	4a. Facility Name (If not institution, give street and number) <i>JOHNS HOPKINS BAYVIEW Medical Center</i>		4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>MD</i>
Funeral Director	5. Social Security Number <i>213-16-9157</i>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>78</i> Yrs.	8. Date of Birth (Month, Day, Year) <i>SEPT. 8, 1921</i>	9. Birthplace (State or Foreign Country) <i>NEW YORK</i>
	Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director	10a. State <i>MD</i>	10b. County <i>BALTIMORE</i>	10c. City, Town or Location <i>DUNDALK</i>		
	10e. Street and Number <i>1941 Merritt Blvd</i>		10f. Zip Code <i>21222</i>		10g. Citizen of What Country? <i>U.S.A.</i>
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <i>White</i>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12 YRS</i> College (1-4or 5+) <i>0</i>		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Administrative Assistant</i>		16b. Kind of Business/Industry <i>BROKERAGE</i>		
	17. Father's Name (First, Middle, Last) <i>HARRY MATTAX</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>ELIZABETH WARD</i>		
	19a. Informant's Name/Relationship (Type, Print) <i>FRANK OWENS (HUSBAND)</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1941 Merritt Blvd Dundalk MD 21222</i>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>OAKLAWN Cemetery</i>		20c. Location - City or Town, State <i>9-1-200 Dundalk, MD</i>
	21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <i>CONNELLY FUNERAL HOME &amp; DUNDALK P.A. 710 SOLLERS PK RD DUNDALK MD 21222</i>		
	23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <i>MYOCARDIAL INFARCTION</i> Due to (or as a consequence of): <i>METASTATIC CANCER</i> Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</i> Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):				
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined					
28a. Date of Injury (Month, Day, Year) <i>August 29, 2000</i>					
28b. Time of Injury <i>M</i>					
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
28d. Describe how Injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and Title of certifier <i>[Signature] MD</i>					
29c. License number <i>21000</i>					
29d. Date signed (Month, Day, Year) <i>August 30, 2000</i>					
30. Name and address of person who completed cause of death (Use 23a) (Type, Print) <i>MARTINE AHMED MD. 4990 EASTERN AVENUE BALTIMORE, MARYLAND 21224</i>					
31. Date filed (Month, Day, Year) <i>SEP 1 2000</i>					
32. Registrar's Signature <i>[Signature]</i>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural," or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27761

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Paul Leroy Phipps

2. Date of Death

AUGUST 26, 2000

3. Time of Death

00:07 AM

4a. Facility Name (If not institution, give street and number)

3700 EAST BALTIMORE STREET

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

220-22-3300

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 6, 1928

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4330 E. Lombard Street

10f. Zip Code

21224

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: Korea13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
9th

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Mixologist

16b. Kind of Business/Industry

Entertainment

17. Father's Name (First, Middle, Last)

George Phipps

18. Mother's Name (First, Middle, Maiden Surname)

Anna Mae Meeka

19a. Informant's Name/Relationship (Type, Print)

Richard D. Stone Jr/Grandson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1510 Rollingside Ave. Baltimore, Maryland 21237

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Bayview Crematory

Date

8/31/00

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service licensee

22. Name and Address of Facility

David J. Weber Funeral Homes, P.A.

401 S. Chester St. Baltimore, Maryland 21231

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?

PARTIAL

1 ☒ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) SCENE

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

OCME

29d. Date signed (Month, Day, Year)

AUGUST 26, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARY G. RIPLE, M.D. 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

SEP 1 2000

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerDivision of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

0027762

REPLACEMENT

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)

ROLAND PLUMMER

2. Date of Death

Month Day Year  
AUG 28 2000

3. Time of Death

8:30 PM

4a. Facility Name (If not institution, give street and number)

Howard County General Hospital

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

5. Social Security Number

060-28-8266

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

73

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
10/24/1926

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2820 Oak Grove Ave.

10f. Zip Code

21227

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No 1/3/45  
If Yes, Give Year or Dates: 10/3/4613. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Consultant

16b. Kind of Business/Industry

self

17. Father's Name (First, Middle, Last)

Harry Osbourne Plummer

18. Mother's Name (First, Middle, Maiden Surname)

Matilda Pauline Wood

19a. Informant's Name/Relationship (Type, Print)

Elizabeth Plummer/ daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1263 Birch Ave. Arbutus, Maryland 21227

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metro Crematory

Date

8/30/00

20c. Location - City or Town, State

Catonsville, Maryland

21. Signature of Funeral Service Licensee

Dean J. Imbrie

22. Name and Address of Facility

Ambrose Funeral Home, Inc.

1328 Sulphur Spring Rd. Arbutus, Maryland 21227

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Adult Respiratory Distress Syndrome

2 days

Due to (or as a consequence of):

b. Nosocomial Pneumonia / Septic Shock

5 days

Due to (or as a consequence of):

c. Subdural Hematoma

~ 4 weeks

Due to (or as a consequence of):

d. Fall with Closed Head Injury - amputee

~ 4 weeks

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Resp failure/Hypoxia, coronary artery disease / non-Q  
wave myocardial infarction, HT, peripheral vascular  
disease & bilateral leg amputations (BKA)  
hypercholesterolemia, hyperglycemia, S/P colostomy  
for rectal cancer

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation  
2 ☒ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)

July 26, 2000 ~ 3:00 PM

28b. Time of Injury

1 ☐ Yes 2 ☒ No

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

fell from standing to concrete floor (BKA's)

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

home

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

2820 Oakgrove Ave Baltimore

29a. Certifier  
(Check only one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

D31473

29d. Date signed (Month, Day, Year)

Oct 24, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PATRYCE A. TOYE, MD 4565 Hemlock Cone Way Ellicott City MD 21042

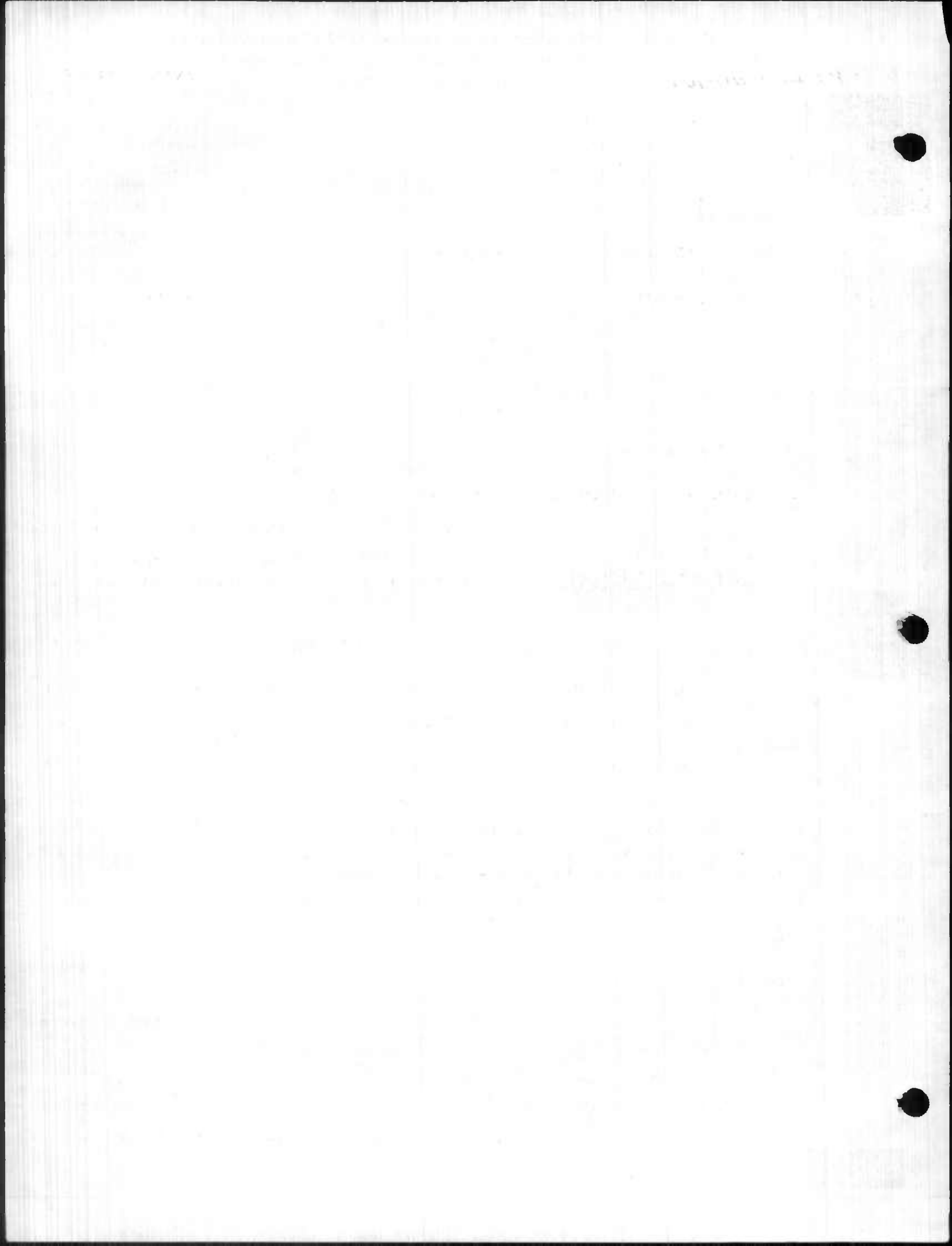
31. Date filed (Month, Day, Year)

OCT 26 2000

32. Registrar's Signature

Benita B. Sparks

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27763

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Bernice Powell</b>		2. Date of Death Month <b>August</b> Day <b>29</b> Year <b>2000</b>		3. Time of Death <b>7:37 PM</b>
	4a. Facility Name (If not institution, give street and number) <b>Sinai Hospital of Baltimore</b>		4b. City, Town, or Location of Death <b>Baltimore City</b>		4c. County of Death
Funeral Director	5. Social Security Number <b>218-36-2436</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>64</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>05 11 36</b>	9. Birthplace (State or Foreign Country) <b>N.C.</b>
	10a. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>3817 Bowers Ave</b>		10f. Zip Code <b>21207</b>
	10g. Citizen of What Country? <b>U.S.A.</b>		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th grade</b> College (1-4or 5+) <b>na</b>
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>House Wife</b>		16b. Kind of Business/Industry <b>Home</b>		17. Father's Name (First, Middle, Last) <b>Birdie Lee Hilliard</b>
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) <b>Idela Hilliard</b>		19a. Informant's Name/Relationship (Type, Print) <b>Gregory &amp; Andrew Powell-Sons</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3817 Bowers Ave, Baltimore Md 21207</b>
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Garrison Forest Vet.</b>		20c. Location - City or Town, State <b>9/5/00 Owings Mills, Md</b>
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <b>March F/H West</b> <b>4300 Wabash Ave, Baltimore Md 21215</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Hyperkalemia</b> Due to (or as a consequence of): <b>Renal Insufficiency</b> Due to (or as a consequence of): <b>Diabetes mellitus</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined
	28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>[Signature]</i> <b>MD</b>		29c. License number <b>RES-000</b>
To Be Completed by Physician/Medical Examiner	29d. Date signed (Month, Day, Year) <b>August 29, 2000</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MARCUS D. SMITH, MD 2401 West Belvedere Baltimore, MD 21215</b>		31. Date filed (Month, Day, Year) <b>SEP 1 2000</b>
	32. Registrar's Signature <i>[Signature]</i>		33. State Registrar <b>SEP 1 2000</b>		

ORIGINAL



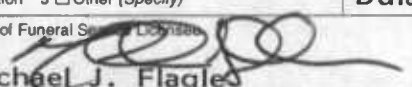
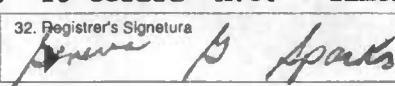
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27764

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Willard J. Prentice</b>				2. Date of Death Month Day Year <b>Aug. 31, 2000</b>		3. Time of Death <b>3:30 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Greater Baltimore Medical Center</b>				4b. City, Town, or Location of Death <b>Towson</b>		4c. County of Death <b>Baltimore</b>		
Funeral Director	5. Social Security Number <b>392-05-1495</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>91</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Oct. 26 1908</b>		
	9. Birthplace (State or Foreign Country) <b>Michigan</b>		10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Timonium</b>		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>2419 Chetwood Circle</b>		10f. Zip Code <b>21093</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>5+</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Civil Engineer</b>		16b. Kind of Business/Industry <b>Army Corps of Engrs.</b>					
17. Father's Name (First, Middle, Last) <b>Joseph Warren Prentice</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ida May Brown</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Warren Stewart Prentice, Sr./Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1 Bromley Ct., Lutherville, MD 21093</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Dulaney Valley Memorial Gardens</b>		20c. Location - City or Town, State <b>Timonium, MD</b>		20d. Date <b>9/2/00</b>			
21. Signature of Funeral Director  <b>Michael J. Flagler</b>				22. Name and Address of Facility <b>Lemmon Funeral Home</b> <b>10 W. Padonia Rd., Timonium, MD 21093</b>					
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Pneumonitis</b> Due to (or as a consequence of):  Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>{</b> Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):		Approximate Interval Between Onset and Death <b>± 1 DAY</b>							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier  <b>Edward P. Costlow MD</b>		29c. License number <b>D19503</b>		29d. Date signed (Month, Day, Year) <b>8-31-2000</b>			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Edward Costlow, M.D. 10 Gerard Ave. Timonium, MD 21093</b>									
31. Date filed (Month, Day, Year) <b>SEP 1 2000</b>		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at 410-326-0000.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27765

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Jeannette Gertrude Schmidt				2. Date of Death Month Day Year August 30 2000		3. Time of Death 6:30PM	
	4a. Facility Name (If not institution, give street and number) Brighton Gardens Of Towson				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 212-74-8501	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 93 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) August 30 1907		9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Towson		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 205 East Joppa Rd. Apt. 1606				10f. Zip Code 21286		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home		
17. Father's Name (First, Middle, Last) Joseph L. Chason				18. Mother's Name (First, Middle, Maiden Surname) Ella Mae Wainwright				
19a. Informant's Name/Relationship (Type, Print) Mr. Edward J. Schmidt, Jr./Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1606 North Lakeshore Dr. Sarasota, Florida 34231				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Moreland Mem. Park		Date 9-2-2000		20c. Location - City or Town, State Baltimore, Md.		
21. Signature of Funeral Service Licensee Jeffrey L. Gair				22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204				
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. ACUTE MYOCARDIAL INFARCTION Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death MINUTES
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION CHRONIC RENAL FAILURE						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)				
29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier N Rosenblum MD				29c. License number D23319		29d. Date signed (Month, Day, Year) Sept 1 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N ROSENBLUM MD 7600 OSCAR DRIVE TOWSON MD 21204								
31. Date filed (Month, Day, Year) SEP 1 2000		32. Registrar's Signature B Sparts						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27766

Amended Item#20c per FHG787 9/5/2000

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Bertha Mae Smith</u>				2. Date of Death Month <u>August</u> Day <u>29</u> Year <u>2000</u>		3. Time of Death <u>8:15 pm</u>		
	4a. Facility Name (If not institution, give street and number) <u>Maryland General Hospital</u>				4b. City, Town, or Location of Death <u>Baltimore City</u>		4c. County of Death		
Funeral Director	5. Social Security Number <u>233-50-2167</u>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <u>92</u> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <u>7 14 1908</u>	9. Birthplace (State or Foreign Country) <u>VA.</u>	
	Usual Residence of Decedent								
10a. State <u>Md</u>		10b. County <u>NIA</u>		10c. City, Town or Location <u>Baltimore</u>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <u>3138 Piedmont Ave.</u>				10f. Zip Code <u>21216</u>		10g. Citizen of What Country? <u>USA.</u>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>Black</u>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>5th</u> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Shower Attendant</u>		16b. Kind of Business/Industry <u>Balto. City School</u>			
17. Father's Name (First, Middle, Last) <u>Marshall King</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Louisiana</u>					
19a. Informant's Name/Relationship (Type, Print) <u>Claude Smith - Son</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>3138 Piedmont Ave. Baltimore, Md. 21216</u>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify):		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Woodlawn Cemetery</u>		Date <u>9-5-2000</u>		20c. Location - City or Town, State <u>Baltimore, MD 21207</u>			
21. Signature of Funeral Service Licensee <u>Jeff Miller</u>				22. Name and Address of Facility <u>Miller's Metropolitan Chapel, P.C. 1639 N. Broadway Balto. Md. 21213</u>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <u>Sepsis</u> Due to (or as a consequence of): b. <u>Septicemia</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Coronary Artery Disease, Atherosclerosis</u>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <u>Alan Rhoades MD</u>		29c. License number <u>89381</u>		29d. Date signed (Month, Day, Year) <u>8/29/00</u>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Alan Rhoades, M.D. 90 Maryland General Hospital</u>									
31. Date filed (Month, Day, Year) <u>SEP 5 2000</u>		32. Registrar's Signature <u>James B. Sparks</u>							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020  
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27767

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>DORIS MARY SPERRY</b>				2. Date of Death Month Day Year <b>AUGUST 31, 2000</b>				3. Time of Death <b>4:05 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>OAKCREST CARE CENTER</b>				4b. City, Town, or Location of Death <b>PARKVILLE</b>				4c. County of Death <b>BALTIMORE</b>		
Funeral Director	5. Social Security Number <b>215-12-8253</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. <b>77</b>		8. Date of Birth (Month, Day, Year) <b>10/20/22</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>		
	Usual Residence of Decedent				10c. City, Town or Location <b>TOWSON</b>		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
10a. State <b>MD</b>		10b. County <b>BALTIMORE</b>		10e. Street and Number <b>519 WEST EPSOM ROAD UNIT 2-C</b>				10f. Zip Code <b>21286</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12TH GRADE</b> College (1-4 or 5+) <b>CUSTOMER SERVICE REP.</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)				16b. Kind of Business/Industry <b>BANKING</b>			
17. Father's Name (First, Middle, Last) <b>JOHN WILLIAM STONE</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>JESSIE MARGARET DECKER</b>							
19a. Informant's Name/Relationship (Type, Print) <b>PATRICIA SPERRY DAUGHTER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>519 WEST EPSOM RD. UNIT 2-C TOWSON, MD 21286</b>							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>PARKWOOD CEMETERY</b>				20c. Location - City or Town, State <b>BALTIMORE, MARYLAND</b>		20d. Date <b>9/2/00</b>	
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Pulmonary Edema</b> Due to (or as a consequence of): <b>b. Chronic Renal failure</b> Due to (or as a consequence of): <b>c. Diabetes mellitus</b> Due to (or as a consequence of): <b>d.</b>										Approximate Interval Between Onset and Death <b>1 day</b> <b>4 years</b> <b>20 years</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <b>D30182</b>		29d. Date signed (Month, Day, Year) <b>August 31, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>William Russell MD 8800 WATTER BLVD BALTIMORE MD 21234</b>											
31. Date filed (Month, Day, Year) <b>SEP 1 2000</b>				32. Registrar's Signature <i>[Signature]</i>							

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27768

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>DONALD SYKES</b>				2. Date of Death Month Day Year <b>AUGUST 29, 2000</b>		3. Time of Death <b>9:36 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>NORTHWEST HOSPITAL CENTER</b>				4b. City, Town, or Location of Death <b>RANDALLSTOWN</b>		4c. County of Death <b>BALTIMORE</b>		
Funeral Director	5. Social Security Number <b>219-58-1995</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>65 Yrs.</b>	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>11-10-1934</b>		9. Birthplace (State or Foreign Country) <b>MD</b>	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>Balto</b>	10c. City, Town or Location <b>Woodlawn</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number <b>6307 Monika Place</b>			10f. Zip Code <b>21207</b>		10g. Citizen of What Country? <b>U.S.A</b>			
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th grade</b>		College (1-4 or 5+) <b>NA</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Contract Worker</b>		16b. Kind of Business/Industry <b>EMERGE Inc</b>		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Dan J. Jenkins</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Adelaide Taylor</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>David Wamsley - Family Friend</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9180 Rumsey Rd Columbia, MD 21045</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Meadowridge Cemetery</b>		20c. Location - City or Town, State <b>9-1-00 Elkridge, MD</b>		20d. Date		
	21. Signature of Funeral Service Licensee <b>Glenn A. Thompson</b>		22. Name and Address of Facility <b>March F.H. West 21215 4300 Wabash Avenue Balto, MD</b>		22b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. ACUTE MYO CARDIAL INFARCTION</b> Due to (or as a consequence of): <b>b. HYPERTENSIVE CARDIOVASCULAR DISEASE</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>1 HOUR</b> <b>YEARS</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>MENTAL RETARDATION</b>						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>[Signature]</b>		29c. License number <b>047587</b>		29d. Date signed (Month, Day, Year) <b>AUGUST 29, 2000</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ROBERT FINE, MD 5401 OLD COURT ROAD, RANDALLSTOWN, MD 21133</b>									
31. Date filed (Month, Day, Year) <b>SEP 1 2000</b>		32. Registrar's Signature <b>[Signature]</b>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27769

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Anna Helen Stahmer</b>				2. Date of Death Month Day Year <b>August 26, 2000</b>				3. Time of Death <b>6:00 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>739 S. Curley Street</b>				4b. City, Town, or Location of Death <b>Baltimore</b>				4c. County of Death <b>N/A</b>		
Funeral Director	5. Social Security Number <b>216-09-0518</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>81</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		
	8. Date of Birth (Month, Day, Year) <b>12/20/1918</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>		
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>739 S. Curley Street</b>				10f. Zip Code <b>21224</b>		10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>				16b. Kind of Business/Industry <b>Domestic</b>		
	17. Father's Name (First, Middle, Last) <b>Anthony Sklodowski</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Golembieski</b>						
	19a. Informant's Name/Relationship (Type, Print) <b>Andrew Stahmer / Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>739 S. Curley Street Baltimore, Maryland 21224</b>						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Holy Rosary Cemetery</b>		Date <b>8/30/00</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>				
	21. Signature of Funeral Service Licensee <i>David J. Weber</i>				22. Name and Address of Facility <b>David J. Weber Funeral Homes, P.A. 401 S. Chester Street Baltimore, Maryland 21231</b>						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>- Renal Failure</b> Due to (or as a consequence of):  b. <b>Alzheimer's Disease</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death						
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown						
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>NA</b>		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Anna H. Curley MD</i>		29c. License number <b>D25436</b>		29d. Date signed (Month, Day, Year) <b>8/29/00</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JEANNE McCauley MD 3100 Wyman Ln. Baltimore MD 21211</b>		31. Date filed (Month, Day, Year) <b>SEP 1 2000</b>		32. Registrar's Signature <i>Benjamin B. Sparks</i>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 000-0000.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27770

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CHARLES OLIVER SHEARS</b>				2. Date of Death Month <b>AUG.</b> Day <b>29</b> , Year <b>2000</b>		3. Time of Death <b>6:30AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>4005 EASTERN AVE.</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>232-05-5094</b>		6. Sex <b>1</b> M <b>2</b> F		7. Age (In yrs. last birthday) <b>84</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>OCT. 20, 1915</b>	
	9. Birthplace (State or Foreign Country) <b>W. VIRGINIA</b>		10a. State <b>MD.</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>	
10d. Inside City Limits <b>1</b> Yes <b>2</b> No		10e. Street and Number <b>4005 EASTERN AVE.</b>		10f. Zip Code <b>21224</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> Yes <b>2</b> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> Yes <b>2</b> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>CUTTER</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry <b>STEEL</b>				
17. Father's Name (First, Middle, Last) <b>OLIVER SHEARS</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>DOLLY POWELL</b>				
19a. Informant's Name/Relationship (Type, Print) <b>RONALD SHEARS/SON</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>905 S. FAGLEY ST., BALTIMORE, MD. 21224</b>				
20a. Method of Disposition <b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GLEN HAVEN MEM. PARK</b>		Date <b>9/2/00</b>		20c. Location - City or Town, State <b>GLEN BURNIE, MD.</b>		
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>CHARLES S. ZEILER &amp; SON, INC. 6224 EASTERN AVE., BALTIMORE, MD. 21224</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Acute Myocardial infarction</b> Due to (or as a consequence of): <b>b. Coronary heart disease</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death <b>5 mins</b> <b>30 yrs</b>						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown		
						24a. Was an autopsy performed? <b>1</b> Yes <b>2</b> No		
						24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> Yes <b>2</b> No		
25. Was case referred to medical examiner? <b>1</b> Yes <b>2</b> No		26. Place of Death (Check only one) Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify)						
27. Manner of Death <b>1</b> Natural <b>2</b> Accident <b>3</b> Suicide <b>4</b> Homicide <b>5</b> Pending investigation <b>6</b> Could not be determined		28a. Date of injury (Month, Day Year)		28b. Time of injury <b>M</b>		28c. Injury at Work? <b>1</b> Yes <b>2</b> No		
		28d. Describe how injury occurred		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29e. Certifier (Check only one) <b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>[Signature]</i> MD				29c. License number <b>D15408</b>		29d. Date signed (Month, Day, Year) <b>8/29/00</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>D.W. MACDONALD M.D. 2801 HUDSON ST BALTO MD 21224</b>								
31. Date filed (Month, Day, Year) <b>SEP 1 2000</b>				32. Registrar's Signature <i>[Signature]</i>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27771

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Nicholas Thomas Savko, Sr.</b>				2. Date of Death Month Day Year <b>August 26, 2000</b>		3. Time of Death <b>11:00 p.m.</b>		
	4a. Facility Name (If not institution, give street and number) <b>Franklin Woods Nursing Center</b>				4b. City, Town, or Location of Death <b>Rosedale</b>		4c. County of Death <b>Baltimore</b>		
Funeral Director	5. Social Security Number <b>224-24-5909</b>		6. Sex <b>MALE</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>77</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>March 13, 1923</b>		
	9. Birthplace (State or Foreign Country) <b>Kentucky</b>		10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Essex</b>		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>956 Homberg Avenue</b>		10f. Zip Code <b>21221</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1944-1946</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>1</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Millwright Foreman</b>		16b. Kind of Business/Industry <b>Steel Mill</b>		17. Father's Name (First, Middle, Last) <b>John Savko, Sr.</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Susie Havay</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Patricia Levi (daughter)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>27 Upman Court, Catonsville, Maryland 21228</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Holly Hill Mem. Gardens</b>		20c. Location - City or Town, State <b>8/31/2000 Baltimore, Maryland</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Bruzdziński Funeral Home, P.A.</b> <b>1407 Old Eastern Avenue, Essex, Maryland 21221</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  a. <b>Hypoxemia</b> Due to (or as a consequence of): b. <b>Aspiration Pneumonia</b> Due to (or as a consequence of): c. <b>Dementia</b> Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death <b>1 day</b> <b>3 days</b> <b>1 year</b>			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Lymphoma</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>D53462</b>		29d. Date signed (Month, Day, Year) <b>8/28/00</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Jude Muneses MD, 7845 Oakwood Road Baltimore, MD 21061</b>		31. Date filed (Month, Day, Year) <b>SEP 1 2000</b>		32. Registrar's Signature 					

*[Faint, illegible text covering the page, possibly bleed-through from the reverse side. The text is too light to transcribe accurately.]*



Certificate of Death

Reg. No.

00 27772

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Shawn Aaron Schnepf				2. Date of Death Month Day Year August 28, 2000		3. Time of Death 4:30 P.M.		
	4a. Facility Name (If not institution, give street and number) Sinai Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A		
Funeral Director	5. Social Security Number 220-13-7867		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 21 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 3, 1979		
	9. Birthplace (State or Foreign Country) Maryland		10. Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location Maryland Baltimore Middle River		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
10e. Street and Number 23 Maxa Court		10f. Zip Code 21220		10g. Citizen of What Country? U.S.A.					
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Logger		16b. Kind of Business/Industry Logging					
17. Father's Name (First, Middle, Last) Charles Francis Schnepf				18. Mother's Name (First, Middle, Maiden Surname) Donna Stroup					
19a. Informant's Name/Relationship (Type, Print) Charles Schnepf (father)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23 Maxa Court, Baltimore, Maryland 21220					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Green Mount Crematory		20c. Date 9/4/2000		20d. Location - City or Town, State Baltimore, Maryland			
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Bruzdinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Head and Chest Injuries Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? 2 <input checked="" type="checkbox"/> Yes 1 <input type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? 2 <input checked="" type="checkbox"/> Yes 1 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 08-28-2000		28b. Time of Injury Unknown M		28c. Injury at Work? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Yard		28d. Describe how injury occurred Subject was struck by a tree while cutting tree.					
		28f. Location (Street and Number or Rural Route Number, City or Town, State) 5500 Wexford Road Baltimore, Maryland							
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier 				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) August 30, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Pestaner, M.D. 111 Penn Street, Baltimore, Maryland 21201									
31. Date filed (Month, Day, Year) SEP 1 2000		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27773

amended item #5 per fh g787 9/1/00 ah

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ROGER SAMUEL SILESKY</b>				2. Date of Death Month Day Year <b>AUGUST 29, 2000</b>		3. Time of Death <b>7:40 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>820 W. 36TH STREET</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>22-24-6085</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>70</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>MAY 5, 1930</b>	
	9. Birthplace (State or Foreign Country) <b>MD</b>		10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number <b>820 W. 36TH STREET</b>		10f. Zip Code <b>21211</b>	
	10g. Citizen of What Country? <b>U.S.A.</b>				11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>PROPRIETOR</b>				16b. Kind of Business/Industry <b>COMPUTER SUPPLIES</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>BENJAMIN B. SILESKY</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>TILLIE MEYER</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>BETSY S. BARON / DAUGHTER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>38 HERITAGE LANE - WESTON, CT 06883</b>			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ARLINGTON CHIZUK AMUNO</b>		20c. Location - City or Town, State <b>8/31/00 BALTIMORE, MD</b>	
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Myocardial Infarction</b>							Approximate Interval Between Onset and Death <b>Minutes</b>
	23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
To Be Completed by Physician/Medical Examiner	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide			
	28a. Date of Injury (Month, Day Year) <b>SEP 1 2000</b>				28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <b>D23076</b>		29d. Date signed (Month, Day, Year) <b>8-29-00</b>	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Richard L. Diamond, M.D. 3730 Falls Road Baltimore, MD 21211</b>							
To Be Completed by Physician/Medical Examiner	31. Data filed (Month, Day, Year) <b>SEP 1 2000</b>				32. Registrar's Signature <i>[Signature]</i>			
	33. Registrar's Name <b>Sparks</b>							

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27774

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EDITH SYDNOR				2. Date of Death Month Day Year AUGUST 31, 2000				3. Time of Death 3:25am		
	4a. Facility Name (If not institution, give street and number) LONG GREEN CENTER GENESIS ELDERCARE				4b. City, Town, or Location of Death BALTIMORE				4c. County of Death N/A		
Funeral Director	5. Social Security Number 216-12-5367		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) 9-17-1919		9. Birthplace (State or Foreign Country) MD.		
	Usual Residence of Decedent										
10a. State MD.		10b. County N/A		10c. City, Town or Location BALTIMORE				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
10e. Street and Number 1013 HARLEM AVE.				10f. Zip Code 21217				10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: BLACK			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) -12- College (1-4 or 5+) -0-				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PRINTER				16b. Kind of Business/Industry CHEMICAL			
17. Father's Name (First, Middle, Last) IRA T. WATERS				18. Mother's Name (First, Middle, Maiden Surname) SERENA KIAH							
19a. Informant's Name/Relationship (Type, Print) RANDOLPH SYDNOR JR. (SON)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 734 WHITMORE AVE. BALTIMORE, MARYLAND 21216							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) GARRISON FOREST VETERANS 9-6-2000 OWINGS MILLS, MARYLAND				20c. Location - City or Town, State					
21. Signature of Funeral Service Licensee Janatha J. Hiberna				22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CEREBROVASCULAR ACCIDENT Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier [Signature] MD				29c. License number D16619				29d. Date signed (Month, Day, Year) August 31, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E. VARGAS-SOARES 1327 N. CHARLES ST. BALTIMORE, MD. 21218											
31. Date filed (Month, Day, Year) SEP 01 2000		32. Registrar's Signature [Signature]									

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27775

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LEONIA TURNER</b>		2. Date of Death Month <b>August</b> Day <b>28</b> Year <b>2000</b>		3. Time of Death <b>3:20 pm</b>						
	4a. Facility Name (If not institution, give street and number) <b>University of Maryland Medical Systems</b>		4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>						
Funeral Director	5. Social Security Number <b>216-24-9359</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>83</b> Yrs.	If Under 1 Year Month <b>0</b> Day <b>0</b>	If Under 24 Hrs. Hours <b>0</b> Min. <b>0</b>						
	8. Date of Birth (Month, Day, Year) <b>AUGUST 8, 1917</b>		9. Birthplace (State or Foreign Country) <b>GEORGIA</b>								
Usual Residence of Decedent											
10a. State <b>MARYLAND</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE CITY</b>							
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No											
10e. Street and Number <b>317 N. STRICKER STREET</b>			10f. Zip Code <b>21223</b>		10g. Citizen of What Country? <b>U.S.A.</b>						
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:							
14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>											
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10TH GRADE</b>		College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>DOMESTIC</b>							
16b. Kind of Business/Industry <b>HANNA TABOR REALTOR</b>											
17. Father's Name (First, Middle, Last) <b>HARRISON LOBB</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>EMMA BLAGGINGAME</b>								
19a. Informant's Name/Relationship (Type, Print) <b>MILDRED GEE (DAUGHTER)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5 WOODHUE COURT, BALTIMORE, MARYLAND 21244</b>								
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MT. CALVARY CEMETERY</b>		20c. Location - City or Town, State <b>09-01-00 GLEN BURNIE, MARYLAND</b>							
21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <b>JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTIMORE, MARYLAND 21217</b>									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
<table border="1"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last         </td> <td>a. <b>Coronary Artery Disease</b> Due to (or as a consequence of):</td> <td rowspan="4">Approximate Interval Between Onset and Death</td> </tr> <tr> <td>b. <b>Diabetes</b> Due to (or as a consequence of):</td> </tr> <tr> <td>c.  Due to (or as a consequence of):</td> </tr> <tr> <td>d.  Due to (or as a consequence of):</td> </tr> </table>						Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. <b>Coronary Artery Disease</b> Due to (or as a consequence of):	Approximate Interval Between Onset and Death	b. <b>Diabetes</b> Due to (or as a consequence of):	c. Due to (or as a consequence of):	d. Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. <b>Coronary Artery Disease</b> Due to (or as a consequence of):	Approximate Interval Between Onset and Death									
	b. <b>Diabetes</b> Due to (or as a consequence of):										
	c. Due to (or as a consequence of):										
	d. Due to (or as a consequence of):										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown											
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No											
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>							
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred									
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner		29b. Signature and title of certifier <i>[Signature]</i>									
29c. License number <b>00054648</b>		29d. Date signed (Month, Day, Year) <b>August 29, 2000</b>									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Geoffrey Nam...</b>											
31. Date filed (Month, Day, Year) <b>SEP 01 2000</b>		32. Registrar's Signature <i>[Signature]</i>									



George William Thompson

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State of Maryland / Department of Health and Mental Hygiene

00 27776

amend item 23a,ptII, 27 per me G787 9/25/00 yf

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GEORGE WILLIAM THOMPSON				2. Date of Death Month: August Day: 27 Year: 2000		3. Time of Death 08:25 P.M.	
	4a. Facility Name (If not institution, give street and number) 5412 Old Court Road				4b. City, Town, or Location of Death Randallstown		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 249-56-0918	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 75 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 7-5-1925		9. Birthplace (State or Foreign Country) SC.
	Usual Residence of Decedent							
10a. State MD.		10b. County BALTIMORE		10c. City, Town or Location RANDALLSTOWN			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 3216 OBJIBY RD.				10f. Zip Code 21133		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: BLACK	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) -8- College (1-4or 5+) -0-				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DRIVER			16b. Kind of Business/Industry SERVICE	
17. Father's Name (First, Middle, Last) OSCAR THOMPSON				18. Mother's Name (First, Middle, Maiden Surname) ROXIE STARKS				
19a. Informant's Name/Relationship (Type, Print) JOYCE MOSLEY (DAUGHTER)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21520 38th AVE, SPANAWAY, WASHINGTON 98387				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MT. CALVARY CEMETERY		Date 9-5-2000		20c. Location - City or Town, State GLEN BURNIE, MARYLAND		
21. Signature of Funeral Service Licensee <i>Joan D. Hibern</i>				22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Scene						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>Stephen S. Radentz, M.D.</i>				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) August 29, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) SEP 01 2000		32. Registrar's Signature <i>B. Sparks</i>						

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27777

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Stanley Vernarelli

2. Date of Death

Month Day Year  
August 29, 2000

3. Time of Death

6:27 a.m.

4a. Facility Name (If not institution, give street and number)

8 Villa Capri Circle

4b. City, Town, or Location of Death

Essex

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

218-28-9572

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 16, 1933

9. Birthplace (State or Foreign Country)

Italy

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Essex

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

3 Villa Capri Circle

10f. Zip Code

21221

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Superintendent

16b. Kind of Business/Industry

Baltimore City Highway

17. Father's Name (First, Middle, Last)

Diodato Vernarelli

18. Mother's Name (First, Middle, Maiden Surname)

Ernestine Poretti

19a. Informant's Name/Relationship (Type, Print)

Lillian Vernarelli (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8 Villa Capri Circle, Essex, Maryland 21221

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GreenMount Crematory

Date

8/30/2000 Baltimore, Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bruzdinski Funeral Home, P.A.

1407 Old Eastern Avenue, Essex, Maryland 21221

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Metastatic Lung Carcinoma

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Two months

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Accident ☐ Suicide ☐ Homicide  
☐ Pending investigation ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Marshall A. Levine, M.D.

29c. License number

D17873

29d. Date signed (Month, Day, Year)

August 30, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6569 North Charles Street Towson, Maryland 21204 Marshall A. Levine

31. Date filed (Month, Day, Year)

SEP 1 2000

32. Registrar's Signature

James A. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





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AMEND#8 PER F.H. G790 12-29-2000 State of Maryland / Department of Health and Mental Hygiene  
amend item 23a per phys. G787 9/1/00 yf

Certificate of Death

Reg. No.

00 27778

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MARGARET WIEGAND</b>				2. Date of Death Month <b>AUGUST</b> , Day <b>23</b> , Year <b>2000</b>		3. Time of Death <b>10<sup>30</sup> A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>SINAI HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>Baltimore City</b>	
Funeral Director	5. Social Security Number <b>220-24-9182</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>77</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth <b>1924</b> (Month, Day, Year) <b>Mar 6, 1924</b>	9. Birthplace (State or Foreign Country) <b>New York</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Howard</b>		10c. City, Town or Location <b>Ellicott City</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>3000 N. Ridge Road</b>				10f. Zip Code <b>21042</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4or 5+) <b>4</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Cytotechnologist</b>		16b. Kind of Business/Industry <b>Medical</b>		
17. Father's Name (First, Middle, Last) <b>Henry Frank Wiegand</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mable Hilsinger</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Mr. Frank Brueckmann</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6605 Carroll Highlands Road Eldersburg, Maryland 21784</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. John's Cemetery</b>		Date <b>08/26/00</b>		20c. Location - City or Town, State <b>Ellicott City, MD</b>
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) <b>RENAL FAILURE.</b>								
Due to (or as a consequence of): <b>Muscle Necrosis</b>								
Due to (or as a consequence of): <b>GANGRENE OF BOTH LOWER EXTREMITIES</b>								
Due to (or as a consequence of):								
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <b>Loony Anton M.D.</b>				29c. License number <b>RES 000</b>		29d. Date signed (Month, Day, Year) <b>AUG 23, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>LOONAS ANTON, 2401 WEST BELVEDERE AVE BALTIMORE, MD 21215</b>								
31. Date filed (Month, Day, Year) <b>SEP 1 2000</b>		32. Registrar's Signature <i>[Signature]</i>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #23 PART I, 27, 28A\_F PER MEO G787 9-18-00 WR.

Certificate of Death

Reg. No.

00 27779

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Pamela J. Weinstein				2. Date of Death Month Day Year AUGUST 28 2000		3. Time of Death 17:31 PM	
	4e. Facility Name (If not institution, give street and number) 1712 BRIAN COURT				4b. City, Town, or Location of Death CROFTON		4c. County of Death ANNE ARUNDEL	
Funeral Director	5. Social Security Number 217-58-8884		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 49 Yrs.		8. Date of Birth (Month, Day, Year) Jan. 6, 1951	
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Crofton	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 1712 Brian Court		10f. Zip Code 21114		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Mutual Clerk		16b. Kind of Business/Industry Race Track				
17. Father's Name (First, Middle, Last) Edward Gemmill				18. Mother's Name (First, Middle, Maiden Surname) Mable Saddler				
19a. Informant's Name/Relationship (Type, Print) Ralph I. Weinstein (Husband)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1712 Brian Court, Crofton, MD 21114				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory		20c. Date 09/02 2000		20d. Location - City or Town, State Baltimore, MD		
21. Signature of Funeral Service Licensee Pamela J. Weinstein		22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  COMBINED DRUG INTOXICATION a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):  Approximate Interval Between Onset and Death								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE						
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury 8/28/00 Found: FOUND: HOME		28b. Time of Injury 5:00 PM Found: FOUND: HOME		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred UNKNOWN		28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify) FOUND: HOME		28f. Location (Street and Number or Rural Route Number, City or Town, State) 1712 BRIAN COURT CROFTON, MARYLAND				
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Pamela J. Weinstein				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) AUGUST 29, 2000		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) MARY G. RIDDLE, M.D., 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) SEP 01 2000		32. Registrar's Signature B. Sparks						

ORIGINAL



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amend item 23b per phys. G788 10/16/00 State of Maryland / Department of Health and Mental Hygiene  
Amended Item#23b per PHYg788 10/10/2000 EW

Certificate of Death

Reg. No.

00 27780

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Frank Wallis</b>		2. Date of Death Month Day Year <b>8/ 25/ 2000</b>		3. Time of Death <b>14:45</b>
	4a. Facility Name (If not institution, give street and number) <b>John's Hopkins Bayview</b>		4b. City, Town, or Location of Death <b>Highlandtown</b>		4c. County of Death <b>Baltimore</b>
Funeral Director	5. Social Security Number <b>218-10-9529</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>80</b>	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>8/9/1920</b>		9. Birthplace (State or Foreign Country) <b>Balto, MD</b>		
Usual Residence of Decedent					
10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>WhiteMarsh</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <b>6047 Loreley Beach Rd</b>			10f. Zip Code <b>21162</b>		10g. Citizen of What Country? <b>USA</b>
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>WW II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 Years</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Steel Metal Mechanic</b>		16b. Kind of Business/Industry <b>Martin Marietta</b>
17. Father's Name (First, Middle, Last) <b>Henry Wallis</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Barbara Younger</b>		
19e. Informant's Name/Relationship (Type, Print) <b>Lula Wallis (wife)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6047 Loreley Beach Rd WhiteMarsh, MD 21162</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Salem United Methodist Ch. Cemetery</b>		20c. Location - City or Town, State <b>8/29/00 Kingsville, MD</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>E.F. Lassahn Funeral Home 11750 Belair Rd. Kingsville, MD 21087</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Multiple Organ System failure</b> Due to (or as a consequence of): <b>b. Sepsis</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>					Approximate Interval Between Onset and Death <b>1 month</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Asbestos Exposure</b>					23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>M</b>		28b. Time of Injury <b>1</b> Yes <input type="checkbox"/> No	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number <b>RES000</b>		29d. Date signed (Month, Day, Year) <b>8/28/00 August, 28 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DAVID NAMI 4940 Eastern Ave Baltimore, Maryland 21224</b>					
31. Date filed (Month, Day, Year) <b>SEP 1 2000</b>		32. Registrar's Signature 			

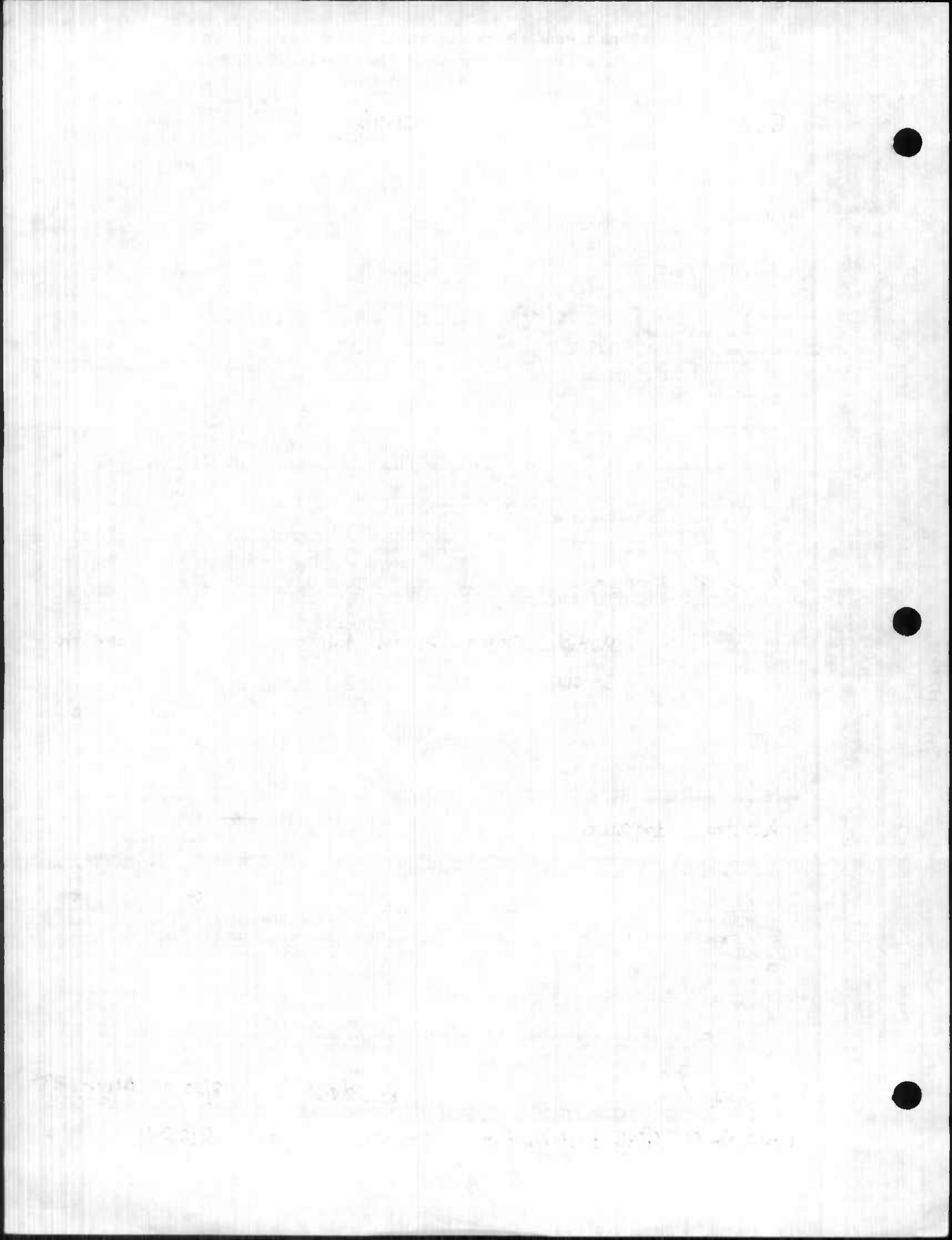
Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





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State of Maryland / Department of Health and Mental Hygiene 00 27781

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Silvia B. Ward				2. Date of Death Month Day Year August 29 2000				3. Time of Death 5:15 am	
	4a. Facility Name (If not institution, give street and number) Genesis Eldercare - Spa Creek				4b. City, Town, or Location of Death Annapolis				4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 553-48-9191		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 72 Yrs.		8. Date of Birth (Month, Day, Year) May 11, 1928		9. Birthplace (State or Foreign Country) New York	
	Usual Residence of Decedent									
10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Edgewater				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 33 Poplar Point Road				10f. Zip Code 21037				10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) News Editor				16b. Kind of Business/Industry Voice of America		
17. Father's Name (First, Middle, Last) Nicholas Divincenzo					18. Mother's Name (First, Middle, Maiden Surname) Josephine Caruso					
19a. Informant's Name/Relationship (Type, Print) Russell H. Ward (Husband)					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 33 Poplar Point Road, Edgewater, MD 21037					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) St. Paul's Cemetery		Date 09/01 2000		20c. Location - City or Town, State Crownsville, MD			
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. Osteomyelitis Due to (or as a consequence of): b. Severe Osteoporosis Due to (or as a consequence of): c. Stroke, cerebral aneurysm Due to (or as a consequence of): d.  Approximate Interval Between Onset and Death 3 mos years										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Urinary infection COPD, Emphysema, Depression, Malnutrition										
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and Title of Certifier 					29c. License number D23142		29d. Date signed (Month, Day, Year) August 29, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S.D. Krimmins, MD, 104 Ridgely Avenue, Annapolis, MD 21401										
31. Date filed (Month, Day, Year) SEP 1 2000		32. Registrar's Signature 								

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

00 27782

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Bobbie NMN White</u>			2. Date of Death Month <u>8</u> Day <u>30</u> Year <u>2000</u>			3. Time of Death <u>8AM</u>				
	4a. Facility Name (If not institution, give street and number) <u>3304 Chesterfield Ave.</u>			4b. City, Town, or Location of Death <u>Baltimore</u>			4c. County of Death <u>City</u>				
Funeral Director	5. Social Security Number <u>227-52-7718</u>		6. Sex <u>1</u> M <u>2</u> F		7. Age (In yrs. last birthday) <u>61</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>8-19-1939</u>		9. Birthplace (State or Foreign Country) <u>VA</u>		
	Usual Residence of Decedent			10a. State <u>MD</u>			10b. County <u>N/A</u>			10c. City, Town or Location <u>BALTIMORE</u>	
10d. Inside City Limits <u>1</u> Yes <u>2</u> No			10e. Street and Number <u>3304 CHESTERFIELD AVE</u>			10f. Zip Code <u>21213</u>			10g. Citizen of What Country? <u>USA</u>		
11. Marital Status <u>1</u> Never Married <u>2</u> Married <u>3</u> Widowed <u>4</u> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <u>1</u> Yes <u>2</u> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <u>1</u> Yes <u>2</u> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <u>BLACK</u>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>10th GRADE</u> College (1-4 or 5+) <u>N/A</u>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>LABORER</u>			16b. Kind of Business/Industry <u>LANDSCAPING</u>					
17. Father's Name (First, Middle, Last) <u>BERNARD GREGORY</u>			18. Mother's Name (First, Middle, Maiden Surname) <u>DORA WHITE</u>			19a. Informant's Name/Relationship (Type, Print) <u>DAISY McCOLLOUGH</u>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>3304 CHESTERFIELD AVE BALTO MD 21213</u>		
20a. Method of Disposition <u>1</u> Burial <u>2</u> Cremation <u>3</u> Removal from State <u>4</u> Donation <u>5</u> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <u>UNION BAPTIST ch. yard 9/3 DILLWYN VA.</u>			20c. Location - City or Town, State					
21. Signature of Funeral Service Licensee <u>[Signature]</u>			22. Name and Address of Facility <u>BETTS FUNERAL HOME</u> <u>1129 N. CAROLINE ST BALTO. MD 21213</u>			23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <u>Unknown</u>			Approximate Interval Between Onset and Death		
Immediate Cause (Final disease or condition resulting in death) <u>Ischemic Heart Disease</u>			Due to (or as a consequence of): <u>Hypertension</u>			Due to (or as a consequence of): <u>End-stage Kidney Failure</u>					
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <u>Aneurysm</u>			Due to (or as a consequence of): <u>Peripheral Vascular Disease</u>			Due to (or as a consequence of): <u>Bloody Pleural Effusion in 7/2000</u>					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Aneurysm</u>			23b. Did tobacco use contribute to the cause of death? <u>1</u> Yes <u>2</u> No <u>3</u> Probably <u>4</u> Unknown			24a. Was an autopsy performed? <u>1</u> Yes <u>2</u> No			24b. Were autopsy findings available prior to completion of cause of death? <u>N/A</u>		
25. Was case referred to medical examiner? <u>1</u> Yes <u>2</u> No			26. Place of Death (Check only one) Hospital: <u>1</u> Inpatient <u>2</u> ER/Outpatient <u>3</u> DOA Other: <u>4</u> Nursing Home <u>5</u> Residence <u>6</u> Other (Specify)			27. Manner of Death <u>1</u> Natural <u>5</u> Pending Investigation <u>2</u> Accident <u>6</u> Could not be determined <u>3</u> Suicide <u>4</u> Homicide			28a. Date of injury (Month, Day, Year) <u>N/A</u>		
28b. Time of injury <u>N/A</u>			28c. Injury at Work? <u>1</u> Yes <u>2</u> No			28d. Describe how injury occurred <u>N/A</u>			28e. Location (Street and Number or Rural Route Number, City or Town, State) <u>N/A</u>		
29a. Certifier (Check only one) <u>2</u> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier <u>[Signature] M.D.</u>			29c. License number <u>D19829</u>			29d. Date signed (Month, Day, Year) <u>8/31/2000</u>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Steve Y. SHEN, 824 N. Eutaw, Ste 401, Balto. Md. 21201</u>			31. Date filed (Month, Day, Year) <u>SEP 1 2000</u>			32. Registrar's Signature <u>[Signature]</u>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 687603

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

copy

copy

3304 CHESTERFIELD

Union Baptist Church / 3 Dillwyn

BETTS FUNERAL HOME  
1124 N. CAROLINE ST. BALTO. MD 21213

*[Handwritten signature]*

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27783

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JOHN J. WINSTEAD</b>				2. Date of Death Month <b>August</b> Day <b>26</b> Year <b>2000</b>		3. Time of Death <b>10:15 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>GOOD SAMARITAN HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>240-74-5058</b>		8. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>76</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>JUNE 6, 1924</b>	
	9. Birthplace (State or Foreign Country) <b>N. CAROLINA</b>							
To Be Completed by Funeral Director	Usual Residence of Decedent							
	10a. State <b>MD.</b>	10b. County <b>NA</b>	10c. City, Town or Location <b>BALTIMORE</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>1320 GITTINGS AVE</b>			10f. Zip Code <b>21229</b>		10g. Citizen of What Country? <b>U.S.A</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (10-12) <b>UTH</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>TABACCO FARMER</b>		16b. Kind of Business/Industry <b>FARMING</b>			
	17. Father's Name (First, Middle, Last) <b>JOHN WINSTEAD</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>LULA BOLLE TALLEY</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>GERALDINE ALEXANDER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1320 GITTINGS AVE, BALTIMORE MD, 21239</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>HYCO ZION BAPTCH, 9-100 ROXBORO NC</b>		20c. Location - City or Town, State <b>BALTIMORE, MD</b>		20d. Date <b>27 OCTOBER 2000</b>	
	21. Signature of Funeral Service Licensee <b>[Signature]</b>		22. Name and Address of Funeral Home <b>CAROL P. MARCH FUNERAL HOME, 270 REDBANK PASS BALT. MD. 21229</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>VENTRICULAR FIBRILLATION</b> Due to (or as a consequence of):  b. <b>CONGESTIVE HEART FAILURE</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  Approximate Interval Between Onset and Death <b>30 min</b> <b>YEAR</b>							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>[Signature] M.D.</b>		29c. License number <b>P 11902</b>		29d. Date signed (Month, Day, Year) <b>Aug 26, 2000</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>NOUHAD DAMAJ 5601 LOCK RAVEN BLVD BALTIMORE MD 21239</b>								
31. Date filed (Month, Day, Year) <b>SEP 1 2000</b>		32. Registrar's Signature <b>[Signature]</b>						

ORIGINAL







Physician /Medical Examiner

HELEN A. WRZESIEN

2. Date of Death Month Day Year AUG. 29, 2000 3. Time of Death 6:00 PM

4a. Facility Name (If not institution, give street and number) 6913 BANK ST. 4b. City, Town, or Location of Death BALTIMORE 4c. County of Death N/A

5. Social Security Number 213-28-8798 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 72 8. Date of Birth (Month, Day, Year) JUNE 10, 1928 9. Birthplace (State or Foreign Country) PA.

Usual Residence of Decedent 10a. State MD. 10b. County N/A 10c. City, Town or Location BALTIMORE 10d. Inside City Limits X Yes 2 No

10e. Street and Number 6913 BANK ST. 10f. Zip Code 21224 10g. Citizen of What Country? USA

11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: 14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CLERK 16b. Kind of Business/Industry SOCIAL SECURITY

17. Father's Name (First, Middle, Last) ADAM ANDREWS 18. Mother's Name (First, Middle, Maiden Surname) MARIE POSHEFKO

19a. Informant's Name/Relationship (Type, Print) STEVE WRZESIEN/SON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21104 7581 PRINCE ANDREW CT., MARIOTTSTVILLE, MD.

20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) ST. STANISLAUS CEM. 20c. Location - City or Town, State BALTIMORE, MD.

21. Signature of Funeral Service Licensee 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVE., BALTIMORE, MD. 21224

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pancreatic Cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. L. HARRIS, JR. 4940 EAGLE AVE. BALTIMORE, MD 21224

31. Date filed (Month, Day, Year) SEP 1 2000 32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27785

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Barbara Walker</u>			2. Date of Death Month <u>August</u> Day <u>29</u> Year <u>2000</u>			3. Time of Death <u>2:10</u>				
	4a. Facility Name (If not institution, give street and number) <u>Stella Maris Hospice at Mercy</u>			4b. City, Town, or Location of Death <u>Baltimore</u>			4c. County of Death				
Funeral Director	5. Social Security Number <u>215-92-5843</u>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <u>33</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>12 21 66</u>		9. Birthplace (State or Foreign Country) <u>Maryland</u>		
	Usual Residence of Decedent			10a. State <u>Md</u>			10b. County <u>N/A</u>			10c. City, Town or Location <u>Baltimore</u>	
To Be Completed by Funeral Director	10e. Street and Number <u>853 N. Streeper Street</u>			10f. Zip Code <u>21205</u>			10g. Citizen of What Country? <u>USA</u>				
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <u>Black</u>			
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>8th</u> College (1-4or 5+) <u></u>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Domestic</u>			16b. Kind of Business/Industry <u>Homemaker</u>				
	17. Father's Name (First, Middle, Last) <u>Russell Varborough Sr.</u>			18. Mother's Name (First, Middle, Maiden Surname) <u>Lillie Mae King</u>							
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <u>Martina Brinson-Sister</u>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>803 Streeper Street Balto. Md. 21205</u>							
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Voshell Cemetery</u>			20c. Location - City or Town, State <u>9-6-200 Baltimore, Maryland</u>				
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Services Licensee <u>[Signature]</u>			22. Name and Address of Facility <u>Miller's Metropolitan Chapel, P.C. 1639 N. Broadway Balto. Md. 21213</u>							
	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			a. <u>Acquired Immunodeficiency Syndrome</u> Due to (or as a consequence of):			b. <u></u> Due to (or as a consequence of):			c. <u></u> Due to (or as a consequence of):	
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <u>hospice</u>							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)			28b. Time of Injury M			28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred			28e. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier <u>[Signature]</u>							
To Be Completed by Physician/Medical Examiner	29c. License number <u>D40854</u>			29d. Date signed (Month, Day, Year) <u>8/30/00</u>							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>David Rosenberg</u> <u>301 St Paul Pl Baltimore 21202</u>										
State Registrar	31. Date filed (Month, Day, Year) <u>SEP 1 2000</u>			32. Registrar's Signature <u>[Signature]</u>							

~~Handwritten scribbles~~

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27786

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Rose M. Wright

2. Date of Death

Aug. 27 2000

3. Time of Death

1:25 PM

4a. Facility Name (If not institution, give street and number)

Southern Maryland Hosp. Center

4b. City, Town, or Location of Death

Clinton, MD

4c. County of Death

PG

Funeral  
Director

5. Social Security Number

579540799

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

59

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 09 1941

9. Birthplace (State or Foreign Country)

Washington DC

Usual Residence of Decedent

10a. State

MD

10b. County

Prince Georges Clinton

10c. City, Town or Location

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8500 Mike Shapiro Dr.

10f. Zip Code

20735

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

9th

College (1-4or 5+)

0

16e. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Sales

16b. Kind of Business/Industry

Retail

17. Father's Name (First, Middle, Last)

Jackson C. Shackelford

18. Mother's Name (First, Middle, Maiden Surname)

Clara Green

19a. Informant's Name/Relationship (Type, Print)

Sandra Lawson daughter 72 Glorieux St. Irvington, NJ 07111

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

MT. Olivet

Date

Sept. 2, 00 Washington, DC

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Leander M. Coles

22. Name and Address of Facility

Tri State Funeral Service  
108 W. North Ave. Balto. MD 21201

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. ACUTE MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No

25. Was case referred to medical

examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Frank Ditraglia

29c. License number

555434

29d. Date signed (Month, Day, Year)

Aug 29, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Frank Ditraglia Po Box 703 West River, Md 20778

State  
Registrar

31. Date filed (Month, Day, Year)

SEP 1 2000

32. Registrar's Signature

Sandra G. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural" or item 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27787

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Christine Adkins</b>				2. Date of Death Month <b>August</b> Day <b>09</b> Year <b>2000</b>		3. Time of Death <b>3:25pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>Harford Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Havre de Grace</b>		4c. County of Death <b>Harford</b>	
Funeral Director	5. Social Security Number <b>158-46-8807</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>48</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>03/10/1952</b>	
	9. Birthplace (State or Foreign Country) <b>New Jersey</b>		10a. State <b>MD</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Aberdeen</b>	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				10e. Street and Number <b>503 Beards Hill Road</b>		10f. Zip Code <b>21001</b>	
	10g. Citizen of What Country? <b>USA</b>				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2 years</b> College (1-4 or 5+) <b>2 years</b>	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Police Officer</b>				16b. Kind of Business/Industry <b>City Government</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Theodore Schulz</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Jean Laurencelle</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Curtis C. Adkins, Jr. - Spouse</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>503 Beards Hill Road, Aberdeen, MD 21001</b>			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Angel Hill Cemetery</b>		20c. Location - City or Town, State <b>8/16/00 Havre de Grace, MD</b>	
	21. Signature of Funeral Service Licensee <b>Melanie M. Smith</b>				22. Name and Address of Facility <b>Mitchell-Smith Funeral Home, P.A. 123 S. Washington, Havre de Grace, MD 21078</b>			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Metastatic Breast Cancer</b>				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28. Date of Injury (Month, Day, Year) <b>8/15/00</b>			
To Be Completed by Physician/Medical Examiner	28a. Date of Injury (Month, Day, Year) <b>8/15/00</b>				28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
To Be Completed by Physician/Medical Examiner	28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
	29b. Signature and title of certifier <b>H. Sup Jim mh</b>				29c. License number <b>046412</b>		29d. Date signed (Month, Day, Year) <b>8/19/00</b>	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>H. Sup Jim 319 S. Union Ave Hdc Mb 21078</b>				31. Date filed (Month, Day, Year) <b>AUG 14 2000</b>			
	32. Registrar's Signature <b>B. Spatz</b>				33. Date of Death (Month, Day, Year) <b>08/16/00</b>			

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

00 27788

Amended Item#25 perPhyG787 9/12/2000 EW

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Leona E. Amorosi				2. Date of Death Month Day Year AUGUST 15, 2000				3. Time of Death 4:16 AM		
	4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center				4b. City, Town, or Location of Death Annapolis				4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 087-07-0018		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 85 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 12, 1914		9. Birthplace (State or Foreign Country) New York		
	Usual Residence of Decedent										
10a. State New York		10b. County Dutchess		10c. City, Town or Location Poughkeepsie				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 31 Feller Court				10f. Zip Code 12603				10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Home			
17. Father's Name (First, Middle, Last) Elmer Tice				18. Mother's Name (First, Middle, Maiden Surname) Emma (unknown)							
19a. Informant's Name/Relationship (Type, Print) Norma L. Fanzo/ Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2104 Sandy Court Crofton, Maryland 21114							
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		Date 8-15-00		20c. Location - City or Town, State Alexandria, VA			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death	
Immediate Cause (Final disease or condition resulting in death) a. <u>Cardiovascular Shock</u> Due to (or as a consequence of): b. <u>Myocardial Infarction</u> Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____										24 hours hours	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										29b. Signature and title of certifier 	
				29c. License number DM35494				29d. Date signed (Month, Day, Year) 8/15/2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Steven Resnick MD Anne Arundel Medical Center											
31. Date filed (Month, Day, Year) AUG 16 2000		32. Registrar's Signature 									

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27789

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Walter G. Behrens</b>				2. Date of Death Month Day Year <b>August 10, 2000</b>				3. Time of Death <b>7:20 A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>638 Andrews Rd.</b>				4b. City, Town, or Location of Death <b>Aberdeen</b>				4c. County of Death <b>Harford</b>	
Funeral Director	5. Social Security Number <b>562-22-9226</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>71</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Dec. 1, 1928</b>		9. Birthplace (State or Foreign Country) <b>California</b>	
	Usual Residence of Decedent				10c. City, Town or Location <b>Aberdeen</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. State <b>MD</b>		10f. County <b>Harford</b>		10g. Citizen of What Country? <b>U.S.A.</b>		10h. Street and Number <b>638 Andrews Rd.</b>		10i. Zip Code <b>21001</b>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>WWII</b> If Yes, Give Year or Dates <b>Korea</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+) <b>0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Civil Service</b>		16b. Kind of Business/Industry <b>U.S Government</b>		17. Father's Name (First, Middle, Last) <b>UNK</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>UNK</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Lois Behrens (Spouse)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>638 Andrews Rd., Aberdeen, Maryland 21001</b>						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Harford Memorial Gardens</b>		20c. Date <b>8/16/00</b>		20d. Location - City or Town, State <b>Aberdeen, Maryland</b>		
21. Signature of Funeral Service Licensee <b>Kenneth B. Cargle</b>				22. Name and Address of Facility <b>Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>PROGRESSIVE POLYNEUROPATHY</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>One Year</b>										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Type 2 Diabetes Mellitus</b>				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown						
				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>[Signature]</b>		29c. License number <b>D0055536</b>		29d. Date signed (Month, Day, Year) <b>8/10/00</b>				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>DAVE L. GORDON, MD 1321 RIVERSIDE PKWY BELCAMP MD 21017</b>										
31. Date filed (Month, Day, Year) <b>AUG 14 2000</b>		32. Registrar's Signature <b>[Signature]</b>								





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State of Maryland / Department of Health and Mental Hygiene

00 27790

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Emma E. Brown</b>				2. Date of Death Month <b>August</b> Day <b>4</b> Year <b>2000</b>		3. Time of Death <b>00:15 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Sunbridge Nursing Home</b>				4b. City, Town, or Location of Death <b>Elkton</b>		4c. County of Death <b>Cecil</b>		
Funeral Director	5. Social Security Number <b>216-24-3970</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>73</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Dec. 26, 1926</b>		
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>MD</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Aberdeen</b>		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>431 Washington Street</b>		10f. Zip Code <b>21001</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Dietary Supervisor</b>		16b. Kind of Business/Industry <b>Rosewood State Hospital</b>		17. Father's Name (First, Middle, Last) <b>Samuel E. Giles</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Florence Green</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Crystal Neal (Daughter)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1914 Hanson Rd., Edgewood, Maryland 21040</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Garrison Forest MD Vet.</b>		20c. Location - City or Town, State <b>8/15/00 Owings Mills, MD</b>	
21. Signature of Funeral Service Licensee <b>Kirsten Amy Unglesbee</b>		22. Name and Address of Facility <b>Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>ASCVD</b> Due to (or as a consequence of): <b>hypertension</b> Due to (or as a consequence of): <b>diabetes mellitus</b> Due to (or as a consequence of):		Approximate Interval Between Onset and Death <b>years</b> <b>years</b> <b>years</b>			
23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>dementia,</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>28</b> 28b. Time of Injury <b>M</b> 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>W. Bruce O'Connell MD</b>		29c. License number <b>00035779</b>		29d. Date signed (Month, Day, Year) <b>8/14/2000 August 14, 2000</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>W. Bruce O'Connell MD</b>		31. Date filed (Month, Day, Year) <b>AUG 14 2000</b>		32. Registrar's Signature <b>G. Sparks</b>					

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27791

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Robert Kroh Bixler		2. Date of Death Month Day Year AUGUST 15, 2000		3. Time of Death 12:19 PM
	4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center		4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore
Funeral Director	5. Social Security Number 217-36-3770	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	8. Date of Birth (Month, Day, Year) Sept. 5, 1915	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State Maryland	10b. County Carroll	10c. City, Town or Location New Windsor		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	10e. Street and Number 950 Wakefield Valley Rd.		10f. Zip Code 21776		10g. Citizen of What Country? U.S.A.
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) farmer		16b. Kind of Business/Industry dairy & grain		
	17. Father's Name (First, Middle, Last) Herbert C. Bixler		18. Mother's Name (First, Middle, Maiden Surname) Carrie Mae Kroh		
	19a. Informant's Name/Relationship (Type, Print) Gale D. Bixler/ daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 950 Wakefield Valley Rd. New Windsor, MD 21776		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Bixlers Church Cemetery		20c. Location - City or Town, State 8/18/00 nr. Westminster, MD
	21. Signature of Funeral Service Licensee Catharine O. Hartzler		22. Name and Address of Facility Hartzler Funeral Home 310 Church St. New Windsor, MD 21776		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) MULTI-SYSTEM ORGAN FAILURE				Approximate Interval Between Onset and Death DAYS
	a. Due to (or as a consequence of): SEPSIS				DAYS
	b. Due to (or as a consequence of):				
	c. Due to (or as a consequence of):				
	d. Due to (or as a consequence of):				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
	26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier Timothy Low, M.D.		29c. License number D 24034		29d. Date signed (Month, Day, Year) 8/15/00	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TIMOTHY LOW, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204					
State Registrar	31. Date filed (Month, Day, Year) AUG 21 2000		32. Registrar's Signature B Sparks		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Physician/Medical Examiner



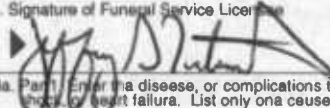
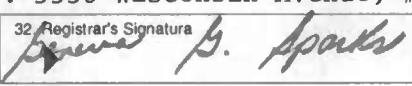
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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27792

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) David Henry Blee				2. Date of Death Month Day Year August 4, 2000		3. Time of Death 7:15 AM		
	4a. Facility Name (If not institution, give street and number) 5051 Westpath Terrace				4b. City, Town, or Location of Death Bethesda		4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 577-60-4412		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 20, 1916		
	9. Birthplace (State or Foreign Country) California		10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Bethesda		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 5051 Westpath Terrace		10f. Zip Code 20816		10g. Citizen of What Country? United States	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No World War II		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) - 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Senior Executive Service		16b. Kind of Business/Industry Central Intelligence Agency					
17. Father's Name (First, Middle, Last) Clarence Earl Blee				18. Mother's Name (First, Middle, Maiden Surname) Leona Lodwick					
19a. Informant's Name/Relationship (Type, Print) Margaret G. Blee/ Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5051 Westpath Terrace, Bethesda, MD 20816					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Montgomery Crematorium Inc.		Date August 5, 2000		20c. Location - City or Town, State Bethesda, Maryland			
21. Signature of Funeral Service Licensee  M00689		22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501							
23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. - CUP - CVA		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and Title of certifier 		29c. License number D0053211		29d. Date signed (Month, Day, Year) August 4, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pasquale Santini, M.D. 5530 Wisconsin Avenue, #1400, Chevy Chase, MD 20815		31. Date filed (Month, Day, Year) AUG 07 2000		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene

amend item 26 per phys. G787 9/8/00 yf

Certificate of Death

Reg. No.

00 27793

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Rosalie L. Brown</b>				2. Date of Death Month <b>August</b> Day <b>21</b> Year <b>2000</b>		3. Time of Death <b>2:20 pm</b>		
	4a. Facility Name (If not institution, give street and number) <b>317 S. University Avenue</b>				4b. City, Town, or Location of Death <b>Federalsburg</b>		4c. County of Death <b>Caroline</b>		
Funeral Director	5. Social Security Number <b>218-40-5778</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>58</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Feb. 1, 1942</b>		
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>MD</b>		10b. County <b>Caroline</b>		10c. City, Town or Location <b>Federalsburg</b>		
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>317 S. University Avenue</b>		10f. Zip Code <b>21632</b>		10g. Citizen of What Country? <b>United States</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) _____		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Packer</b>		16b. Kind of Business/Industry <b>Solo Cup Company</b>				
	17. Father's Name (First, Middle, Last) <b>Eldridge Smith</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Alberta Meredith</b>				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>William A. Brown/Spouse</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>317 S. University Ave., Federalsburg, MD 21632</b>				
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cambridge Crematory</b>		Data <b>8/22</b>		20c. Location - City or Town, State <b>Cambridge, MD</b>		
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <b>Michael F. Eskow</b>				22. Name and Address of Facility <b>Frampton-Hawkins-Eskow Funeral Home, PA PO Box 43, Federalsburg, MD 21632</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Breast Cancer</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____							Approximate Interval Between Onset and Death <b>5 yrs</b>	
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
	29b. Signature and title of certifier <b>[Signature]</b>		29c. License number <b>B37887</b>		29d. Date signed (Month, Day, Year) <b>8/21/00.</b>				
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>David Smith, M.D., 29466 Pintail Dr. Suite #5, Easton, MD 21601</b>								
	31. Date filed (Month, Day, Year) <b>AUG 22 2000</b>		32. Registrar's Signature <b>[Signature]</b>						



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State of Maryland / Department of Health and Mental Hygiene

00 27794

## Certificate of Death

Reg. No.

Physician (Medical Examiner)	1. Decedent's Name (First, Middle, Last) <b>James Henry Broughton</b>				2. Date of Death Month <b>August</b> Day <b>16</b> Year <b>2000</b>		3. Time of Death <b>8:56 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>111 Sadler Rd</b>				4b. City, Town, or Location of Death <b>Grasonville</b>		4c. County of Death <b>Queen Anne</b>	
Funeral Director	5. Social Security Number <b>216-20-6831</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>74</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>July 31, 1926</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Caroline</b>		10c. City, Town or Location <b>Greensboro</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>417 N Academy Street</b>				10f. Zip Code <b>21639</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>1944-</b> If Yes, Give Year or Dates: <b>1946</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>contractor</b>		16b. Kind of Business/Industry <b>self employed</b>		
17. Father's Name (First, Middle, Last) <b>Horace Broughton</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Florence Walters</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Dorothy Broughton spouse</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>417 N Academy St Greensboro, Maryland 21639</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Chesapeake Cremation Center</b>		Date <b>Aug 19, 2000</b>		20c. Location - City or Town, State <b>Chester, Maryland</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Fleegle - Helfenbein Funeral Home PA PO Box 160 Greensboro, Maryland 21639</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Myocardial Infarction</b> Due to (or as a consequence of): <b>b. Hypertension</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>minutes</b> <b>years</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, fam, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number <b>016964</b>		29d. Date signed (Month, Day, Year) <b>8-17-00</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>James Chacon MD 1509 Ritchie Hwy Annapolis MD 21012</b>								
31. Date filed (Month, Day, Year) <b>AUG 18 2000</b>		32. Registrar's Signature 						

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

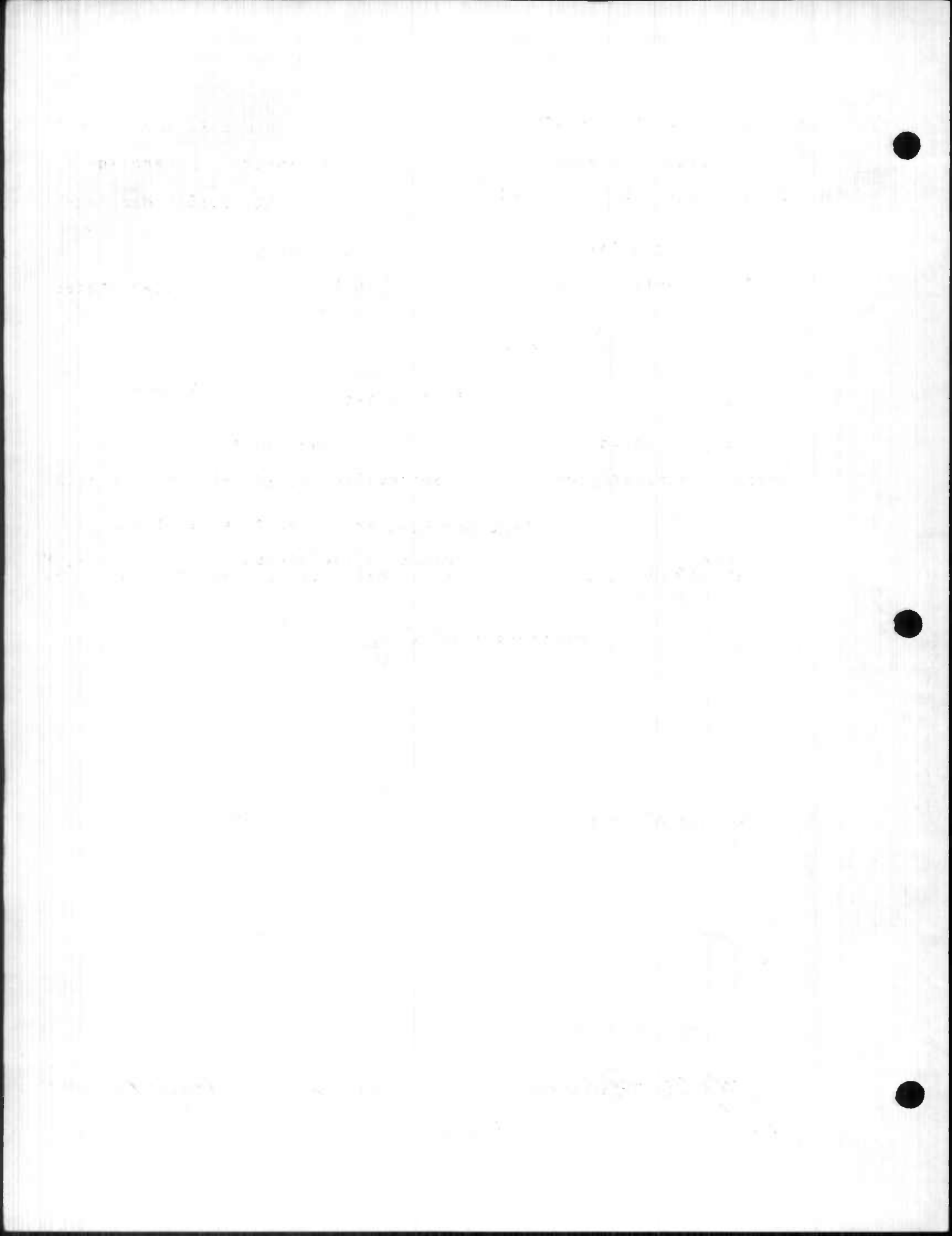
00 27795

amend item 24aper phys. G787 9/8/00 yf

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Roland Edward Bennett</b>				2. Date of Death Month <b>August</b> Day <b>16</b> Year <b>2000</b>		3. Time of Death <b>12:45 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>5576 Smithville Road</b>				4b. City, Town, or Location of Death <b>Federalsburg</b>		4c. County of Death <b>Caroline</b>	
Funeral Director	5. Social Security Number <b>213-22-9208</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>74</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Aug. 19, 1925</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>Caroline</b>		10c. City, Town or Location <b>Federalsburg</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>5576 Smithville Road</b>			10f. Zip Code <b>21632</b>		10g. Citizen of What Country? <b>United States</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>42-46</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Truck Driver</b>		16b. Kind of Business/Industry <b>Trucking</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>George Bennett</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Agnes Tolson</b>			
	19a. Intendant's Name/Relationship (Type, Print) <b>Shirley Bennett/Spouse</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5576 Smithville RD, Federalsburg, MD 21632</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Bloomery Cemetery</b>		Date <b>8/17</b>		20c. Location - City or Town, State <b>Federalsburg, MD</b>	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Frampton-Hawkins-Eskow Funeral Home, PA 216 N. Main St. Federalsburg, MD 21632</b>					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Carcinoma of Lung</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death <b>3 yrs</b>							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Blocked Artery</b>						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
			28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
State Registrar	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>D26388</b>		29d. Date signed (Month, Day, Year) <b>August 17, 2000</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Michael Padden 302 Collins, Harlock MD 21643</b>							
	31. Date filed (Month, Day, Year) <b>AUG 17 2000</b>		32. Registrar's Signature 					





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27796

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Paul Lee Carr

2. Date of Death

August 16

2000

3. Time of Death

9:00 AM

4a. Facility Name (If not institution, give street and number)

LORION AT RIVERSIDE

4b. City, Town, or Location of Death

Berkamp Maryland

4c. County of Death

HARFORD

Funeral  
Director

5. Social Security Number

235-36-5286

6. Sex

152 M 20 F

7. Age (In yrs. last birthday)

72

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Mar. 18, 1928

9. Birthplace (State or Foreign Country)

W. Va.

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Fallston

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

1605-A Bel Air Road

10f. Zip Code

21047

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 Never Married 2 Married  
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (14 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Custodian

16b. Kind of Business/Industry

Board of Education

17. Father's Name (First, Middle, Last)

William Carr

18. Mother's Name (First, Middle, Maiden Surname)

Bertha Martin

19a. Informant's Name/Relationship (Type, Print)

Lloyd H. Burton (Nephew)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1605-A Bel Air Rd., Fallston, MD 21047

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State  
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

R. A. Ferris &amp; Co., Inc. 8/17/00 West Chester, PA

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Kenneth B. Bargo

22. Name and Address of Facility

Tarring-Cargo Funeral Home, P.A.  
Aberdeen, Maryland 21001-3399

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardio respiratory Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Pneumonia

Due to (or as a consequence of):

c. Esophageal cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

26. Place of Death (Check only one)

Other:

4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide  
5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

J Lee M.D.

29c. License number

D206661

29d. Date signed (Month, Day, Year)

7/16/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J T Lee M.D., 669 Revolution St. Harne de Grace MD. 21078

31. Date filed (Month, Day, Year)

AUG 18 2000

32. Registrar's Signature

David B. Sparks

State  
RegistrarPAUL L. CARR  
Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27797

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>RICHARD W. CRAWFORD</b>				2. Date of Death Month <b>08</b> Day <b>10</b> Year <b>00</b>		3. Time of Death <b>230p</b>		
	4a. Facility Name (If not institution, give street and number) <b>BALTIMORE VA MED CENTER</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>BALTIMORE</b>		
Funeral Director	5. Social Security Number <b>218-18-9274</b>		6. Sex <b>1</b> M <b>2</b> F		7. Age (In yrs. last birthday) <b>76</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>August 7, 1924</b>		
	10a. State <b>MD</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Abingdon</b>		10d. Inside City Limits <b>1</b> Yes <b>2</b> No		
10e. Street and Number <b>3847 Memory Lane</b>				10f. Zip Code <b>21009</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
11. Marital Status <b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> Yes <b>2</b> No If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> Yes <b>2</b> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Businessman</b>		16b. Kind of Business/Industry <b>Sales</b>			
17. Father's Name (First, Middle, Last) <b>Robert J. Crawford</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lucile Stuart</b>					
19e. Informant's Name/Relationship (Type, Print) <b>Mrs. Karen L. Schorah</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>817 Giles St., Havre de Grace, Maryland 21078</b>					
20e. Method of Disposition <b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Bel Air Memorial Gardens</b>		Date <b>8/15/00</b>		20c. Location - City or Town, State <b>Bel Air, Maryland</b>		
21. Signature of Funeral Service Licensee <b>Kirkon Arnyllingbee</b>				22. Name and Address of Facility <b>Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. SEPSIS</b> Due to (or as a consequence of): <b>b. PNEUMONIA</b> Due to (or as a consequence of): <b>c. ENDOCARDITIS</b> Due to (or as a consequence of): <b>d.</b>								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown	
								24a. Was an autopsy performed? <b>1</b> Yes <b>2</b> No	
								24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> Yes <b>2</b> No	
25. Was case referred to medical examiner? <b>1</b> Yes <b>2</b> No				26. Place of Death (Check only one) Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify)					
27. Manner of Death <b>1</b> Natural <b>5</b> Pending Investigation <b>2</b> Accident <b>6</b> Could not be determined <b>3</b> Suicide <b>4</b> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1</b> Yes <b>2</b> No	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29e. Certifier (Check only one) <b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <b>Kovrateng W.D</b>				29c. License number <b>P12643</b>	
				29d. Date signed (Month, Day, Year) <b>08/10/00</b>					
30. Name and address of person who completed cause of death (from 23a) (Type, Print) <b>Konbera O. Isoateng</b>									
31. Date filed (Month, Day, Year) <b>AUG 14 2000</b>				32. Registrar's Signature <b>B. Sparks</b>					

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27798

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Samuel James Cropper Jr.

2. Date of Death

Month

Day

Year

3. Time of Death

August 15 2000 7:15pm

4a. Facility Name (If not institution, give street and number)

Manokin Manor

4b. City, Town, or Location of Death

Princess Anne

4c. County of Death

Somerset

Funeral  
Director

5. Social Security Number

228-18-2252

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)

12-01-19

9. Birthplace (State or Foreign Country)

VA

Usual Residence of Decedent

10a. State

MD

10b. County

Worcester

10c. City, Town or Location

Pocomoke City

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

933 Clark Avenue

10f. Zip Code

21851

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Equipment Driver

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Samuel J. Cropper Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Etta Fletcher Dickerson

19a. Informant's Name/Relationship (Type, Print)

Marie Cropper

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

933 Clark Ave Pocomoke, MD 21851

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Friendship U.M. Church

Date

8/19/00

20c. Location - City or Town, State

Wattsville, VA

21. Signature of Funeral Service Licenses

Bennie Smith Funeral Home

22. Name and Address of Facility

P.O. Box 331 Pocomoke City, MD 21851

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Carcinoma of Prostate - bone

Due to (or as a consequence of):

Metastases

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Approximate interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Renal insufficiency 2° to hydro-nephrosis. Deep Vein Thrombosis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Gregorio M. Bellosso, M.D.

29c. License number

D 29505

29d. Date signed (Month, Day, Year)

8-16-2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GREGORIO M. BELLOSO, M.D.; 5302 CHINABERRY DR., SALISBURY, MD 21801

31. Date filed (Month, Day, Year)

AUG 18 2000

32. Registrar's Signature

B. Sparks

State  
RegistrarSamuel Cropper  
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Handwritten text at the top of the page, possibly a header or introductory paragraph.

Second section of handwritten text, continuing the narrative or list.

Third section of handwritten text, featuring a prominent horizontal line across the middle.

Fourth section of handwritten text, appearing as a separate paragraph.

Fifth section of handwritten text, continuing the flow of the document.

Sixth section of handwritten text, located near the bottom of the page.

Final section of handwritten text at the very bottom of the page.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended Item #5, per F.D.  
08/24/2000, Carroll County, wjl

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27799

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RAYMOND A. CLARK		2. Date of Death Month Day Year AUG. 19, 2000		3. Time of Death 6:00 AM
	4a. Facility Name (If not institution, give street and number) 2055 MANCHESTER RD.		4b. City, Town, or Location of Death WESTMINSTER		4c. County of Death CARROLL
Funeral Director	5. <del>146-12-0261</del> 140-12-0261	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) 9/14/1912		9. Birthplace (State or Foreign Country) New Jersey		
Usual Residence of Decedent					
10a. State MD.		10b. County CARROLL		10c. City, Town or Location WESTMINSTER	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
10e. Street and Number 2055 MANCHESTER RD.		10f. Zip Code 21157		10g. Citizen of What Country? USA.	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: WHITE					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ASSEMBLY LINE		16b. Kind of Business/Industry MANUFACTURING	
17. Father's Name (First, Middle, Last) RAYMOND CLARK		18. Mother's Name (First, Middle, Maiden Surname) ESTELLE STULTZ			
19a. Informant's Name/Relationship (Type, Print) FLORINE KROUSE -DAUGHTER		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2055 MANCHESTER RD., WESTMINSTER, MD. 21157			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) EVERGREEN CEMETERY		20c. Location - City or Town, State 8/23/00 NORTH BRUNSWICK, NJ.	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. End Stage Renal disease ~ 5 yrs Due to (or as a consequence of): b. Coronary artery disease ~ 10 yrs Due to (or as a consequence of): c. Abdominal Aortic Aneurysm ~ 5 yrs Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of a examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D 51705	
29d. Data signed (Month, Day, Year) 8-19-2000					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. PANSURAYA, MD 419F Malcolm DR Westminister MD 21157					
State Registrar	31. Date filed (Month, Day, Year) AUG 21 2000		32. Registrar's Signature 		

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27800

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ADDIE J. COHEN</b>				2. Date of Death Month Day Year <b>AUGUST 21 2000</b>		3. Time of Death <b>1:45 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>SHORE NURSING &amp; REHABILITATION CTR.</b>				4b. City, Town, or Location of Death <b>DENTON</b>		4c. County of Death <b>CAROLINE</b>		
Funeral Director	5. Social Security Number <b>250-26-9454</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>87 Yrs.</b>		8. Date of Birth (Month, Day, Year) <b>Sep. 6, 1912</b>		
	9. Birthplace (State or Foreign Country) <b>S. Carolina</b>								
Usual Residence of Decedent									
10a. State <b>MD</b>		10b. County <b>Caroline</b>		10c. City, Town or Location <b>Federalsburg</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>903 Gardens Court</b>				10f. Zip Code <b>21632</b>		10g. Citizen of What Country? <b>United States</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+) <b>College</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>			
17. Father's Name (First, Middle, Last) <b>Frank Jones</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Missouria Beckett</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Neomi C. Friend/Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>312 Smith Street, Federalsburg, MD 21632</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Federal Hill Cemetery</b>		20c. Location - City or Town, State <b>8/25 Federalsburg, MD</b>			
21. Signature of Funeral Service Licensee <b>Michael F. Eskow</b>				22. Name and Address of Facility <b>Frampton-Hawkins-Eskow Funeral Home, PA PO Box 43, Federalsburg, MD 21632</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Renal failure</b> Due to (or as a consequence of): <b>b. Cerebrovascular accident</b> Due to (or as a consequence of): <b>c. Hypertension</b> Due to (or as a consequence of): <b>d.</b>								Approximate Interval Between Onset and Death <b>3 months</b> <b>3 months</b> <b>20 years</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier <b>MD</b>				29c. License number <b>00051132</b>		29d. Date signed (Month, Day, Year) <b>8-22-00</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JORGE ABREGO, M.D. P.O. BOX 660 DENTON, MD 21629</b>									
31. Date filed (Month, Day, Year) <b>AUG 24 2000</b>				32. Registrar's Signature <b>G. Sparks</b>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

1  
x  
x  
x

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27801

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

John Thomas Dyer Jr.

2. Date of Death

Month Day Year  
Aug 23 2000

3. Time of Death

1:15 AM

4a. Facility Name (If not institution, give street and number)

Caroline Nursing Home

4b. City, Town, or Location of Death

Denton

4c. County of Death

Caroline

Funeral  
Director

5. Social Security Number

218-10-9677

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Jan 30, 1919

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Caroline

10c. City, Town or Location

Greensboro

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

110 Wheeler Dr

10f. Zip Code

21639

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No 1943-  
If Yes, Give  
Year or Dates: 194513. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

service station owner/operator

16b. Kind of Business/Industry

service station

17. Father's Name (First, Middle, Last)

John Thomas Dyer Sr

18. Mother's Name (First, Middle, Maiden Surname)

Pearl Adla Laramore

19a. Informant's Name/Relationship (Type, Print)

Dorothy Dyer/ spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

110 Wheeler Dr Greensboro, Maryland 21639

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Greensboro Cemetery

Date

Aug 25

20c. Location - City or Town, State

Greensboro, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Fleegle - Helfenbein Funeral Home PA

PO Box 160 Greensboro, Maryland 21639

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. Congestive heart Failure

Approximate  
Interval Between  
Onset and Death

month

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebrovascular accident

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☐ Physician2 ☒ Medical ExaminerCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

MD D 31376

29d. Date signed (Month, Day, Year)

8-23-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James Sikes 920 Market St Denton MD

31. Date filed (Month, Day, Year)

AUG 24 2000

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

## State of Maryland / Department of Health and Mental Hygiene

amend item 23a,27, 28a,b,c,e,d,f Per Me G787 9/1/00 yf **Certificate of Death**

Reg. No.

00 27802

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>VIVIAN L. DOUGLAS</b>				2. Date of Death Month Day Year <b>May 07, 2000</b>		3. Time of Death <b>4:20 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Magnolia Center</b>				4b. City, Town, or Location of Death <b>Lanham</b>		4c. County of Death <b>Prince George's</b>	
Funeral Director	5. Social Security Number <b>577-42-5666</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>78</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>9/2/1921</b>		9. Birthplace (State or Foreign Country) <b>Guyana</b>
	Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Silver Spring</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>3930 Bel Pre Road, #5</b>				10f. Zip Code <b>20906</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>4</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Administrative</b>			16b. Kind of Business/Industry <b>Private Industry</b>	
17. Father's Name (First, Middle, Last) <b>Lazarus Douglas</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Sarah Peters</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Sherry Bonner / Friend</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>442 Peabody Street, NW Washington, DC 20011</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Howard U. Coll. of Med.</b>		Data <b>5/8/00</b>		20c. Location - City or Town, State <b>Washington, DC</b>		
21. Signature of Funeral Service Licensee <i>Lori V. Lincoln</i>				22. Name and Address of Facility <b>Lincoln &amp; Lincoln Funeral Service 4315 Anacostia Ave., NE Washington, DC 20019</b>				
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stroke, or heart failure. List only one cause on each line. <b>CLOSED HEAD INJURY WITH COMPLICATIONS</b>		Approximate Interval Between Onset and Death <b>months</b>						
Immediate Cause (Final disease or condition resulting in death)		Due to (or as a consequence of): <b>ATHEROSCLEROTIC cardiovascular disease</b>						
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Due to (or as a consequence of):						
		Due to (or as a consequence of):						
		Due to (or as a consequence of):						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>April 30, 1999</b>		28b. Time of Injury <b>1:05</b> P M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>pedestrian struck by bus</b>
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>road</b>				28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>Wisconsin Circle near Wisconsin Avenue, Washington, D.C.</b>		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>Lori V. Lincoln</i>				29c. License number <b>D41978</b>		29d. Date signed (Month, Day, Year) <b>5-25-2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>N Tavaraki, 1 Hosp Dr Charet, N.D 20785</b>								
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 1 2000</b>		32. Registrar's Signature <i>B Sparks</i>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27803

amend item 26 per phys. G787 9/14/00 yf

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Lemuel Charles Dyott</b>				2. Date of Death Month Day Year <b>August 13 2000</b>		3. Time of Death <b>1:30 AM</b>										
	4a. Facility Name (If not institution, give street and number) <b>8370 Tuckahoe Road</b>				4b. City, Town, or Location of Death <b>Denton</b>		4c. County of Death <b>Caroline</b>										
Funeral Director	5. Social Security Number <b>220-01-1684</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>83</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>March 26, 1917</b>										
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Caroline</b>		10c. City, Town or Location <b>Denton</b>										
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>8370 Tuckahoe Road</b>		10f. Zip Code <b>21629</b>		10g. Citizen of What Country? <b>United States</b>											
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Caucasian</b>											
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Maintenance</b>		16b. Kind of Business/Industry <b>State Roads</b>													
17. Father's Name (First, Middle, Last) <b>Thomas Edward Dyott</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Naomi Viola Foster</b>													
19a. Informant's Name/Relationship (Type, Print) <b>Laura Belle Dyott Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8370 Tuckahoe Road, Denton, Maryland 21629</b>													
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Greenmount Cemetery</b>		20c. Location - City or Town, State <b>8/17/00 Hillsboro, Maryland</b>													
21. Signature of Funeral Service Licensee <i>Randolph P. Moore</i>				22. Name and Address of Facility <b>Moore Funeral Home, P.A. 12 South Second Street, Denton, Maryland 21629</b>													
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																	
<table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last         </td> <td>a.</td> <td><i>congestive heart failure</i></td> <td rowspan="4">           Approximate Interval Between Onset and Death   <b>4 months</b>   <b>3 years</b> </td> </tr> <tr> <td>b.</td> <td><i>coronary artery disease</i></td> </tr> <tr> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a.	<i>congestive heart failure</i>	Approximate Interval Between Onset and Death  <b>4 months</b>  <b>3 years</b>	b.	<i>coronary artery disease</i>	c.		d.	
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a.	<i>congestive heart failure</i>	Approximate Interval Between Onset and Death  <b>4 months</b>  <b>3 years</b>														
	b.	<i>coronary artery disease</i>															
	c.																
	d.																
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																	
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown																	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No													
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)															
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)											
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																	
29b. Signature and title of certifier <i>Matthew J. Fischer, MD</i>				29c. License number <b>D52251</b>		29d. Date signed (Month, Day, Year) <b>8/16/00</b>											
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Matthew J Fischer MD 2 Martin Court Suite 1 Easton MD 21601</b>																	
31. Date filed (Month, Day, Year) <b>AUG 21 2000</b>		32. Registrar's Signature <i>Benjamin S. Sparks</i>															

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27804

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIAM HORACE EICHELBERGER

2. Date of Death

Month  
AUGUSTDay  
23,Year  
2000

3. Time of Death

4:50 A.M.

4a. Facility Name (If not institution, give street and number)

Berlin Nursing and Rehabilitation Center

4b. City, Town, or Location of Death

Berlin

4c. County of Death

Worcester

Funeral  
Director

5. Social Security Number

186-01-7063

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

91

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
9/24/1908

9. Birthplace (State or Foreign Country)

VA

Usual Residence of Decedent

10a. State

MD

10b. County

Worcester

10c. City, Town or Location

Berlin

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

#1 Meadow St.

10f. Zip Code

21811

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Farmer

16b. Kind of Business/Industry

Agriculture

17. Father's Name (First, Middle, Last)

James Walker Eichelberger

18. Mother's Name (First, Middle, Maiden Surname)

Mabel Nock

19a. Informant's Name/Relationship (Type, Print)

Pierce Eichelberger/ Cousin

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

PO Box 53 Quinby, VA 23423

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Cape Henlopen Crematory 8/23/00 Frankford, DE

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Burbage Funeral Home  
108 William St. Berlin, MD 21811Physician  
/Medical  
Examiner23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Pneumonia Bilateral

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death1 week

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Arteriosclerosis CardiovascularPeripheral Vascular disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D02026

29d. Date signed (Month, Day, Year)

8-23-2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. FEDERICO ARTHES, 46 TEAL CIRCLE, BERLIN, MD 21811

410-641-4400

31. Date filed (Month, Day, Year)

AUG 24 2000

32. Registrar's Signature

State  
Registrar

EICHELBERGER, WILLIAM

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Handwritten text, possibly a signature or date, located in the center-right area of the page.



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27806

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MILDRED AYDELOTTE GREBB

2. Date of Death

Month

Day

Year

August 16, 2001

3. Time of Death

2:00

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

5. Social Security Number

219-14-3607

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

10/6/1924

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Worcester

10c. City, Town or Location

Berlin

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

328 William St.

10f. Zip Code

21811

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

18e. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Insurance Broker

16b. Kind of Business/Industry

Insurance Co.

17. Father's Name (First, Middle, Last)

Elwood Aydelotte

18. Mother's Name (First, Middle, Maiden Surname)

Ruth Wilkins

19a. Informant's Name/Relationship (Type, Print)

George Grebb/ Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

328 William St. Berlin, MD 21811

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Evergreen Cemetery

Date

8/19/00

20c. Location - City or Town, State

Berlin, MD

21. Signature of Funeral Service Licensee

Harry M. Henderson 000284

22. Name and Address of Facility

The Burbage Funeral Home  
108 William St., Berlin, Md. 2181123a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a.

Cardiac Arrhythmia

Approximate  
Interval Between  
Onset and Death

30 mins

Due to (or as a consequence of):

b.

Congestive Heart Failure

2 months

Due to (or as a consequence of):

c.

Coronary Artery Disease

5 years

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Renal failure 2° Vasculitis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Benito S. Chan MD

29c. License number

D-20050

29d. Date signed (Month, Day, Year)

8/17/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BENITO S. CHAN 547-B Riverdale Dr. Salisbury, MD 21801

State  
Registrar

31. Date filed (Month, Day, Year)

AUG 18 2000

32. Registrar's Signature

Benito S. Chan

MILWAUKEE 641133  
219-14-3607

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural," or items 23a or 28a-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27805

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MILDRED GUTHRIE GRIGGS</b>		2. Date of Death Month <b>08</b> Day <b>22</b> Year <b>2000</b>		3. Time of Death <b>1630</b>
	4a. Facility Name (If not institution, give street and number) <b>ATLANTIC GENERAL HOSPITAL</b>		4b. City, Town, or Location of Death <b>BERLIN</b>		4c. County of Death <b>WORCESTER</b>
Funeral Director	5. Social Security Number <b>239-05-3247</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>92</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>10-23-07</b>		9. Birthplace (State or Foreign Country) <b>GA.</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State <b>MD..</b>	10b. County <b>MONTGOMERY</b>	10c. City, Town or Location <b>SILVER SPRING</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <b>3431 S. LEISURE WORLD BLVD.</b>		10f. Zip Code <b>20906</b>		10g. Citizen of What Country? <b>U.S.A.</b>
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>MILLINER</b>		16b. Kind of Business/Industry <b>CLOTHING</b>		
	17. Father's Name (First, Middle, Last) <b>CLIFFORD E. HARRISON</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>MARY FRANCES MCNEILL</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>NANCY WEBER/ DAUGHTER</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>71 SANDYHOOK RD. OCEAN PINES, MD. 21811</b>		
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>SALISBURY CREMATORY</b>		20c. Location - City or Town, State <b>8-23 SALISBURY, Md.</b>
	21. Signature of Funeral Service Licensee <i>John A. Ullrich</i>		22. Name and Address of Facility <b>ULLRICH FUNERAL HOME BERLIN, MD. 21811</b>		
Physician /Medical Examiner	23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Sudden Death Syndrome</b> Due to (or as a consequence of): <b>b. Myocardial Infarction</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death <b>1 hr</b> <b>hrs.</b>
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Pulmonary Hypertension</b> <b>Coronary Heart Failure</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
Medical Certification: To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
	29b. Signature and title of certifier <i>William Todd</i>		29c. License number <b>D46111</b>		29d. Date signed (Month, Day, Year) <b>8/23/00</b>
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>William Todd Atlantic Gen. Hosp Emerg Dept Berlin MD</b>				
State Registrar	31. Date filed (Month, Day, Year) <b>AUG 24 2000</b>		32. Registrar's Signature <i>B. Spauld</i>		

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27807

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Harold Glen Hall</b>				2. Date of Death Month Day Year <b>August 9, 2000</b>				3. Time of Death <b>9:15 P.M.</b>		
	4a. Facility Name (If not institution, give street and number) <b>2106 Brown Street</b>				4b. City, Town, or Location of Death <b>Edgewood</b>				4c. County of Death <b>Harford</b>		
Funeral Director	5. Social Security Number <b>217-64-0183</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>45</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Dec. 14, 1954</b>		9. Birthplace (State or Foreign Country) <b>Alabama</b>		
	Usual Residence of Decedent										
10a. State <b>Maryland</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Edgewood</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number <b>2106 Brown Street</b>				10f. Zip Code <b>21040</b>				10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (14 or 5+) <b></b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Disabled</b>				16b. Kind of Business/Industry <b>N/A</b>			
17. Father's Name (First, Middle, Last) <b>Joseph Manford Hall</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mae Lean Lauderdale</b>							
19a. Informant's Name/Relationship (Type, Print) <b>Linda E. Kelley- sister</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>707 Cedar Crest Court, Edgewood, Maryland 21040</b>							
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) Entombment				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Bel Air Memorial Gardens</b>				20c. Location - City or Town, State <b>8/15/00 Bel Air, Maryland</b>			
21. Signature of Funeral Service Licensee <i>Jelly McComas Pennington</i>				22. Name and Address of Facility <b>McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. coronary artery disease</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. &gt;1 year</b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b>											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>chronic renal failure</b>											
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>Linda Fucich</i>				29c. License number <b>028339</b>		29d. Date signed (Month, Day, Year) <b>August 11, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Linda Fucich 101 E Wheel Road Bel Air MD 21015</b>											
31. Date filed (Month, Day, Year) <b>AUG 15 2000</b>				32. Registrar's Signature <i>B. Apple</i>							

Baltimore, Maryland 21215-0020

perm. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

8





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27808

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Evelyn Merritt Hastings</b>				2. Date of Death Month <b>August</b> Day <b>17</b> Year <b>2000</b>		3. Time of Death <b>1:05 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>9430 Libertytown Rd.,</b>				4b. City, Town, or Location of Death <b>Berlin</b>		4c. County of Death <b>Worcester</b>	
Funeral Director	5. Social Security Number <b>214-32-0405</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>74</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>April 24, 1926</b>	
	9. Birthplace (State or Foreign Country) <b>MD</b>		10a. State <b>MD</b>		10b. County <b>Worcester</b>		10c. City, Town or Location <b>Berlin</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>9430 Libertown Rd.,</b>		10f. Zip Code <b>21811</b>		10g. Citizen of What Country? <b>US</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>II</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Seamstress</b>		16b. Kind of Business/Industry <b>Shirt Factory</b>				
17. Father's Name (First, Middle, Last) <b>Willard Merritt</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lula Bowen</b>				
19a. Informant's Name/Relationship (Type, Print) <b>June Taylor Moreau (daughter)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. Box 771, Berlin, Md. 21811</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Sunset Memorial Park</b>		Date <b>8/19/00</b>		20c. Location - City or Town, State <b>Berlin, Maryland</b>		
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>The Burbage Funeral Home</b> <b>108 William St., Berlin, Md. 21811</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. <b>Metastatic Adenocarcinoma of the Lung</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.				Approximate Interval Between Onset and Death <b>months</b>		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic Obstructive Pulmonary Disease</b>						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>D30619</b>		29d. Date signed (Month, Day, Year) <b>8/17/00</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Peter Abbott, M.D. 10445 Ocean City Blvd., Berlin, Md. 21811</b>								
31. Date filed (Month, Day, Year) <b>AUG 18 2000</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural," or item 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

amend item 25 per phys G787 9/1/00

Amend #1 HCHD 7/26/00 brh Certificate of Death

Reg. No.

00 27809

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>JOHNS W. HOPKINS III</u>				2. Date of Death Month <u>JULY</u> Day <u>20</u> Year <u>2000</u>		3. Time of Death <u>0132 hrs.</u>	
	4a. Facility Name (If not institution, give street and number) <u>GOOD SAMARITAN HOSPITAL 5601 LOCH RAVEN BLVD. BALTIMORE.</u>				4b. City, Town, or Location of Death		4c. County of Death	
Funeral Director	5. Social Security Number <u>215-32 4841</u>		6. Sex <u>MALE</u> <input type="checkbox"/> F <input checked="" type="checkbox"/> M		7. Age (In yrs. last birthday) <u>67</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>4/1/1933</u>	
	9. Birthplace (State or Foreign Country) <u>Maryland</u>		10a. State <u>Missouri</u>		10b. County <u>St. Louis</u>		10c. City, Town or Location <u>St. Louis</u>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <u>30 Kingsbury Place</u>		10f. Zip Code <u>63112</u>		10g. Citizen of What Country? <u>USA</u>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify <u>White</u>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>5 +</u> College (1-4or 5+) <u>5 +</u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Professor- College</u>		16b. Kind of Business/Industry <u>Education</u>		17. Father's Name (First, Middle, Last) <u>Johns W. Hopkins Jr.</u>		
18. Mother's Name (First, Middle, Maiden Surname) <u>Margaret Robinson</u>		19a. Informant's Name/Relationship (Type, Print) <u>Margaret L. Hopkins- wife</u>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>30 Kingsbury Place, St. Louis, MO 63112</u>		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		
20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Eagle Evans Crematory</u>		20c. Date <u>7/22/00</u>		20d. Location - City or Town, State <u>Leola, PA</u>		21. Signature of Funeral Service Licensee <u>Jeffrey P. Kavelidge</u>		
22. Name and Address of Facility <u>Harkins F.H. Inc., 600 Main St., Delta, PA 17314</u>		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <u>SEPTIC SHOCK.</u> Due to (or as a consequence of): <u>RENAL FAILURE</u> Due to (or as a consequence of): <u>GASTROINTESTINAL BLEEDING.</u> Due to (or as a consequence of):		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		
28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <u>Ratna Nair PGY2</u>		
29c. License number <u>P 13965.</u>		29d. Date signed (Month, Day, Year) <u>JULY 20 2000</u>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>RATNA NAIR, GOOD SAMARITAN HOSPITAL, 5601 LOCH RAVEN BLVD. BALTIMORE.</u>		31. Date filed (Month, Day, Year) <u>JUL 24 2000</u>		
32. Registrar's Signature <u>[Signature]</u>		33. State Registrar		34. State Registrar		35. State Registrar		

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27810

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Dorothy Jackson

2. Date of Death

Month Day Year  
August 13 2000

3. Time of Death

4:20 AM

4a. Facility Name (If not institution, give street and number)

Mallard Bay Care Center

4b. City, Town, or Location of Death

Cambridge

4c. County of Death

Dorchester

5. Social Security Number

219-07-7179

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct. 16, 1915

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State  
MD

10b. County

Dorchester

10c. City, Town or Location

Cambridge

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

520 Glenburn Avenue

10f. Zip Code

21613

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

6

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Production Line Worker Seasonal Factories

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

Willie Jackson

18. Mother's Name (First, Middle, Maiden Surname)

Annie Ennels

19a. Informant's Name/Relationship (Type, Print)

William Jackson, Sr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

526 Pine Street Cambridge, Maryland 21613

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Bethel Cemetery

Date

8/19/2000

20c. Location - City or Town, State

Cambridge, Maryland

21. Signature of Funeral Service Licensee

Janelle C. Henry

22. Name and Address of Facility

HENRY FUNERAL HOME P.A.

510 Washington St. Cambridge, Maryland 21613

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

5 yrs

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Diabetes Mellitus

Due to (or as a consequence of):

5 yrs

c. \_\_\_\_\_

Due to (or as a consequence of):

d. \_\_\_\_\_

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to this cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Michael Fradden MD

29c. License number

D26388

29d. Date signed (Month, Day, Year)

August 15, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Fradden MD 302 Collins, Harlock MD 21643

31. Date filed (Month, Day, Year)

AUG 16 2000

32. Registrar's Signature

B. Sparks

State  
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27811

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>INEZ EVA KIDWELL</b>				2. Date of Death Month Day Year <b>AUG 20 2000</b>		3. Time of Death <b>3:45 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>CIVISTA MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>LAPLATA</b>		4c. County of Death <b>CHARLES</b>	
Funeral Director	5. Social Security Number <b>213-22-1118</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>86</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Sept 6 1913</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Charles</b>		10c. City, Town or Location <b>Waldorf</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>11518 Terrace Drive</b>				10f. Zip Code <b>20602</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Housewife</b>			16b. Kind of Business/Industry <b>Own Home</b>	
17. Father's Name (First, Middle, Last) <b>Jerry D. Robey</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Laura Williams Robey</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Wesley S. Kidwell (Son)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11518 Terrace Drive Waldorf, MD 20602</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Oakland Cemetery</b>		Date <b>8-23-00</b>		20c. Location - City or Town, State <b>Waldorf, MD</b>		
21. Signature of Funeral Service Licensee  <b>M00173</b>				22. Name and Address of Facility <b>Eberwein Funeral Services 4433 White Pls. 1a. White Pls., MD 20695</b>				
Physician /Medical Examiner	23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>a. Failure to Thrive</b> Due to (or as a consequence of): <b>b. Atrial Fibrillation with rapid heart rate</b> Due to (or as a consequence of): <b>c. Acute GI Bleed - Gastroenterostomy</b> Due to (or as a consequence of): <b>d.</b>						Approximate Interval Between Onset and Death <b>days</b> <b>days</b> <b>weeks</b>	
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number <b>D-46046</b>		29d. Date signed (Month, Day, Year) <b>8-20-00</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>AMIR A MIRZA ALIKHANI MD 118 LAGRANGE AVE. P.O. BOX 1890 LAPLATA MD 20646</b>								
31. Date filed (Month, Day, Year) <b>AUG 23 2000</b>				32. Registrar's Signature 				

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27812

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) Marion Louise Kimball 2. Date of Death Month August Day 19, Year 2000 3. Time of Death 12:01AM

4a. Facility Name (If not Institution, give street and number) Manorcare Health Services/Ruxton 4b. City, Town, or Location of Death Towson 4c. County of Death Baltimore

Funeral  
Director

5. Social Security Number 112 - 24 - 6285 6. Sex 1 ☐ M 2 ☒ F 7. Age (In yrs. last birthday) 68 Yrs. 8. Date of Birth (Month, Day, Year) Apr 28, 1932 9. Birthplace (State or Foreign Country) Connecticut

Usual Residence of Decedent

10a. State Maryland 10b. County Carroll 10c. City, Town or Location Sykesville 10d. Inside City Limits 1 ☐ Yes 2 ☒ No

10e. Street and Number 242 Klee Mill Road 10f. Zip Code 21784 10g. Citizen of What Country? U.S.A.

11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify: 14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker 16b. Kind of Business/Industry Own Home

17. Father's Name (First, Middle, Last) Paul Helbig 18. Mother's Name (First, Middle, Maiden Surname) Emilie Fischer

19a. Informant's Name/Relationship (Type, Print) Robert P. Kimball/Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2927 Alconbury Court Abingdon, Maryland 21009

20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory, or other place) Carroll Cremation, Inc. Date 8/22/2000 20c. Location - City or Town, State Hampstead Maryland

21. Signature of Funeral Service Licensee 22. Name and Address of Facility Jeffrey N. Zumbun Funeral Home & Monument Co. 6028 Sykesville Road Eldersburg, Maryland 21784

23a. Part I (Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.) 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

Immediate Cause (Final disease or condition resulting in death) a. CARCINOMA of LUNG Due to (or as a consequence of): weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

congestive cardiomyopathy Diabetes Mellitus

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier 29c. License number D-12849 29d. Date signed (Month, Day, Year) 8-21-00

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) AH. GHILADI, MD. 7600 OSLER Dr. TOWSON Md. 21204

31. Date filed (Month, Day, Year) AUG 21 2000 32. Registrar's Signature B Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Anthony W. Hall

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27813

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>LOLA ETHEL LEONARD</b>				2. Date of Death Month <b>AUGUST</b> Day <b>15</b> Year <b>2000</b>		3. Time of Death <b>9:10 A.M.</b>	
4a. Facility Name (If not institution, give street and number) <b>MARINER HEALTH OF FOREST HILL</b>				4b. City, Town, or Location of Death <b>FOREST HILL</b>		4c. County of Death <b>HARFORD</b>	
5. Social Security Number <b>212-14-3941</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>87</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>June 8, 1913</b>	
9. Birthplace (State or Foreign Country) <b>North Carolina</b>							
Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Bel Air</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>409 Vale Road</b>				10f. Zip Code <b>21014</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+) _____				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>	
17. Father's Name (First, Middle, Last) <b>James Frank Anderson</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Minnie Ada Cleary</b>			
19a. Informant's Name/Relationship (Type, Print) <b>James Leonard/Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>611 Plumtree Road, Bel Air, MD 21015</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Bel Air Memorial Gardens</b>		Date <b>8/18/00</b>		20c. Location - City or Town, State <b>Bel Air, MD</b>	
21. Signature of Funeral Service Licensee <i>Charles A. Emge</i>				22. Name and Address of Facility <b>McComas Funeral Home, P.A.</b> <b>1317 Cokesbury Road, Abingdon, MD 21009</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <i>dehydration</i> Due to (or as a consequence of):  b. <i>progressive dementia</i> Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <i>David S. Dunn</i>				29c. License number <b>D32299</b>		29d. Date signed (Month, Day, Year) <b>August 16, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>David S. Dunn</i>							
31. Date filed (Month, Day, Year) <b>AUG 17 2000</b>				32. Registrar's Signature <i>[Signature]</i>			

00-08-17 P12:58 IN

00-08-17 P12:58 IN

00-08-17 P12:58 IN

AUG 17 2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27814

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Shirley Dean Russell Leftridge

2. Date of Death

August

Day

13

Year

2000

3. Time of Death

9:17am

4a. Facility Name (If not institution, give street and number)

4104 Conowingo Road Lot 10

4b. City, Town, or Location of Death

Darlington

4c. County of Death

Harford

Funeral  
Director

5. Social Security Number

424-48-5988

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

60

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

10/27/1939

9. Birthplace (State or Foreign Country)

Alabama

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Darlington

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

10e. Street and Number

4104 Conowingo Road Lot 10

10f. Zip Code

21034

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

2 Years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Computer Assistant

16b. Kind of Business/Industry

Civil Service Government

17. Father's Name (First, Middle, Last)

Murphy Russell

18. Mother's Name (First, Middle, Maiden Surname)

Gladys Jones

19a. Informant's Name/Relationship (Type, Print)

R. Paul Leftridge- Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4104 Conowingo Rd., Lot 10, Darlington, MD 21034

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Darlington Cemetery

Date

08/18/00

20c. Location - City or Town, State

Darlington, MD

21. Signature of Funeral Service Licensee

*Julie M. Smith*

22. Name and Address of Facility

Mitchell-Smith Funeral Home, P.A.

123 S. Washington, Havre de Grace, MD 21078

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

*Metastatic Breast Cancer*

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

*1 year*

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Dementia*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*B. J. Leftridge, MD, FACP*

29c. License number

H39022

29d. Date signed (Month, Day, Year)

August 15, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BETTER Leftridge, DO FACP 1308 Business Center Way Edgewood MD

31. Date filed (Month, Day, Year)

AUG 15 2000

32. Registrar's Signature

*James B. Smith*State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

DATE: 10/10/2001  
BY: [illegible]  
RE: [illegible]

[illegible text]

[illegible text]

[illegible text]

[illegible text]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM# #12 PER F.H. G789 11-30-00 WR.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM# #26 PER F.H. G789 11-29-00 WR.

## Certificate of Death

Reg. No.

00 27815

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Carroll Eugene Laramore

2. Date of Death

Month Day Year  
August 21 2000

3. Time of Death

2:00 PM

4a. Facility Name (If not institution, give street and number)

8451 Gannon Circle

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

5. Social Security Number

212-12-3810

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
October 26, 1919

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

Caroline

10c. City, Town or Location

Denton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7390 Statum Road

10f. Zip Code

21629

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates:

1945-

1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:  
Caucasian15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11 HS Grad.

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working

life. DO NOT use retired)

Farmer

16b. Kind of Business/Industry

Farming

17. Father's Name (First, Middle, Last)

Carroll Laramore

18. Mother's Name (First, Middle, Maiden Surname)

Ethel Catherine Adams

19a. Informant's Name/Relationship (Type, Print)

Suzie Murdoch Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8451 Gannon Circle, Easton, Maryland 21601

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Concord Cemetery

Date

8/25/00

20c. Location - City or Town, State

near Denton, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Moore Funeral Home, P.A.

12 South Second Street, Denton, Maryland 21629

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Acute Myocardial Infarction

Due to (or as a consequence of):

b. ASHD with Coronary Artery Disease / Complete Heart Block

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

minutes

9 yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

COPD with Asthmatic Bronchitis

DM II

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☒ Other (Specify)

DAUGHTER'S HOME

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

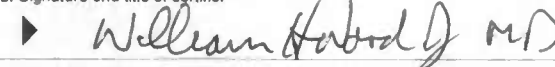
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier



29c. License number

1208715

29d. Date signed (Month, Day, Year)

8/24/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William H. Wood, Jr., 505 Dutchman's Lane, Easton, Maryland 21601

31. Date filed (Month, Day, Year)

32. Registrar's Signature



AUG 25 2000

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

ADMEND ITEM: #26 PER VERBAL RECORD Maryland Department of Health and Mental Hygiene  
Amend #10 & 19b, 8/18/2000, drw

00 27816

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Larry O Lehman</b>		2. Date of Death Month <b>Aug</b> Day <b>10</b> Year <b>2000</b>		3. Time of Death <b>9 15 AM</b>
	4a. Facility Name (If not Institution, give street and number) <b>5971 Ketch Road</b>		4b. City, Town, or Location of Death <b>Prince Frederick Calvert</b>		4c. County of Death
Funeral Director	5. Social Security Number <b>188 34 2686</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>56</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>Jan 29 1944</b>	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State <b>Maryland</b>	10b. County <b>Calvert</b>	10c. City, Town or Location <b>Prince Frederick- Southampton</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <b>5971-Ketch-Road</b>		10f. Zip Code <b>20678-18966</b>		10g. Citizen of What Country? <b>United States</b>
To Be Completed by Physician/Medical Examiner	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>65-67</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>5+</b>		
To Be Completed by Physician/Medical Examiner	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Aerospace engineer</b>		16b. Kind of Business/Industry <b>US Navy</b>		
	17. Father's Name (First, Middle, Last) <b>John Holland Lehman</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Emily Dolliney</b>		
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Carol Lehman - wife</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5971-Ketch Rd. Prince Frederick MD 20678</b> <b>same as 10e</b>		
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Hillside Cemetery</b>		20c. Location - City or Town, State <b>Aug 14 2000 Roslyn PA</b>
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <b>Rausch</b>		22. Name and Address of Facility <b>Rausch Funeral Home PA</b> <b>4405 Brookes Is. Rd. Port Republic Maryland 20676</b>		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Pancreatic Carcinoma</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>		Approximate Interval Between Onset and Death <b>years</b>		
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>SUMMER HOME</b>		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>28b. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</b> <b>28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</b> <b>28d. Describe how injury occurred</b> <b>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</b> <b>28f. Location (Street and Number or Rural Route Number, City or Town, State)</b>		
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>David J. Tardio MD</b>		
	29c. License number <b>047610</b>		29d. Date signed (Month, Day, Year) <b>August 11, 2000</b>		
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>David Tardio MD Prince Frederick Maryland 20678</b>		31. Date filed (Month, Day, Year) <b>AUG 14 2000</b>		
	32. Registrar's Signature <b>B. Sparks</b>		33. State Registrar <b>State Registrar</b>		





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended Item #5 per F.D.  
8/24/2000 Carroll Co.-jab

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27817

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ruth Ellen Maring				2. Date of Death Month Day Year Aug 15, 2000		3. Time of Death 5:30. PM	
	4a. Facility Name (If not institution, give street and number) Westminster Nursing Center				4b. City, Town, or Location of Death Westminster		4c. County of Death Carroll	
Funeral Director	5. Social Security Number 213-26-7602		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 71 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 10, 1928	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Carroll		10c. City, Town or Location Woodbine	
Usual Residence of Decedent								
10a. State Maryland			10b. County Carroll			10c. City, Town or Location Woodbine		
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			10e. Street and Number 2236 Gillis Rd.			10f. Zip Code 21797		
10g. Citizen of What Country? United States			11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+)		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Book Keeper			16b. Kind of Business/Industry Baltimore Livestock			17. Father's Name (First, Middle, Last) Page H. Hidey		
18. Mother's Name (First, Middle, Maiden Surname) Ester M. Schaible			19a. Informant's Name/Relationship (Type, Print) Aubrey DeWitt Maring (Husband)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2236 Gillis Rd. Woodbine, MD 21797		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Lake View Memorial Park			20c. Location - City or Town, State 8/19/00 Sykesville, MD		
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Burrier-Queen Funeral Directors, P.A. 1212 West Old Liberty Rd. Winfield, MD 21784					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Sepsis</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)			28b. Time of Injury M		
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 			29c. License number D25443			29d. Date signed (Month, Day, Year) 8/16/2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John W. Middleton 688 Poole Road, Westminster, MD 21157								
31. Date filed (Month, Day, Year) AUG 21 2000			32. Registrar's Signature 					

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27818

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIAM FRANKLIN MILLS				2. Date of Death Month Day Year August 15, 2000		3. Time of Death 11:00AM	
	4a. Facility Name (If not institution, give street and number) Takoma Park Adventist Hospital				4b. City, Town, or Location of Death Takoma Park		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 578-01-4256		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Aug. 13, 1916	9. Birthplace (State or Foreign Country) Washington D.C.
	Usual Residence of Decedent							
10a. State Maryland		10b. County Carroll		10c. City, Town or Location New Windsor			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number 2804 Carlisle Dr.				10f. Zip Code 21776		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PBX installer		16b. Kind of Business/Industry Phone Company		
17. Father's Name (First, Middle, Last) William N. Mills				18. Mother's Name (First, Middle, Maiden Surname) Madie Gallahan				
19a. Informant's Name/Relationship (Type, Print) Betty J. Mills/wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2804 Carlisle Dr. New Windsor, MD 21776				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Evans Cemetery		Date 8/22/00		20c. Location - City or Town, State Bow, New Hampshire		
21. Signature of Funeral Service Licensee Catherine O. Shaffer				22. Name and Address of Facility Hartzler Funeral Home 310 Church St. New Windsor, MD 21776				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Congestive Heart Failure Due to (or as a consequence of): Coronary Artery Disease  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Renal insufficiency								Approximate Interval Between Onset and Death 4 days
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal insufficiency						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier Robert J. Gold MD				29c. License number D29300		29d. Date signed (Month, Day, Year) August 16, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Gold 15225 Shady Grove Rd. Rockville, Md. 20850								
31. Date filed (Month, Day, Year) AUG 21 2000		32. Registrar's Signature B. Sparks						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM: #23 PART I PER MEO G787 9/1-00 WR  
amend item 28a,b,c,d,e,f per me G787 9/1/00 yf

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No.

00 27819

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Thomas W. Montross

2. Date of Death

Month Day Year  
July 3, 2000

3. Time of Death

2256

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral  
Director

5. Social Security Number

142-42-4450

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

50

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

March 13, 1950

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10a. State

Virginia

10b. County

Accomack

10c. City, Town or Location

Temperanceville

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

10542 Atlantic Road

10f. Zip Code

23442

10g. Citizen of What Country?

U. S. A.

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No  
If Yes, Give Year or Dates: 1968-1972

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Owner Heating And Air Conditioning Self

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

Daniel Montross

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Cashin

19a. Informant's Name/Relationship (Type, Print)

Karen Montross Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10542 Atlantic Road, Temperanceville, Va. 23442

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

John Taylor Cemetery

Date

7-7-00

20c. Location - City or Town, State

Temperanceville, Va.

21. Signature of Funeral Service Licensee

Constance Delmonte Bailey

21b. Name and Address of Facility

Chincoteague, Virginia 23336

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

GUN SHOT WOUND OF HEAD

Immediate Cause (Final disease or condition resulting in death)

a. Gun Shot Wound

Due to (or as a consequence of):

b. Brain Death

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Alcohol use

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient

☐ ER/Outpatient

☐ DOA

Other:

☒ Nursing Home

☒ Residence

☐ Other (Specify)

27. Manner of Death

☐ Natural

☐ Accident

☒ Suicide

☐ Homicide

☐ Pending investigation

☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

July 3, 2000

28b. Time of Injury

9:30 PM

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred subject inflicted

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Home

28f. Location (Street and Number or Rural Route Number, City or Town, State) 10542 Atlantic Road Temperanceville, VA

29e. Certifier (Check only one)

☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

MD MONTROSS

29c. License number

DS4217

29d. Date signed (Month, Day, Year)

7/3/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alon Davis MD MONTROSS 3 Bistate Blvd Delmar MD 21875

31. Date filed (Month, Day, Year)

JUL 07 2000

32. Registrar's Signature

B. Sparks

State  
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Anthony Montross  
Baltimore, Maryland 21215-0020

WIC  
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at 410-326-7000.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM: 8 PER F.H. 6788 10-4-00 WR. State of Maryland / Department of Health and Mental Hygiene

00 27820

Amend #26 as per physician 8/21/00 CCHD fcb Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MARY GOLDIE MADDOX</b>				2. Date of Death Month Day Year <b>AUGUST 16, 2000</b>				3. Time of Death <b>2:32 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>CIVISTA MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>LAPLATA</b>				4c. County of Death <b>CHARLES</b>	
Funeral Director	5. Social Security Number <b>213-42-8461</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>95</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>01-29-1905</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent				10a. State <b>Maryland</b>		10b. County <b>Charles</b>		10c. City, Town or Location <b>Indian Head</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number <b>5385 Stuckey Road</b>				10f. Zip Code <b>20640</b>	
	10g. Citizen of What Country? <b>United States</b>				11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Cook</b>				16b. Kind of Business/Industry <b>Private Homes</b>				17. Father's Name (First, Middle, Last) <b>Charles Henry Ashton</b>	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) <b>Daisey Helen Queen</b>				19a. Informant's Name/Relationship (Type, Print) <b>William T. Maddox/Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5385 Stuckey Road, Indian Head, Maryland 20640</b>	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Charles Cemetery</b>				20c. Location - City or Town, State <b>Indian Head, Maryland</b>	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Williams Funeral Home, P.A. 20640</b>				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>pneumonia</b> <b>coronary artery disease</b>	
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day, Year)				28b. Time of Injury <b>M</b>				28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 				29c. License number <b>D-22574</b>	
To Be Completed by Physician/Medical Examiner	29d. Date signed (Month, Day, Year) <b>8/16/00</b>				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ROBERT T. PACE M.D. 12070 OLD LINE CENTER SUITE 202 WALDORF MD. 20602</b>				31. Date filed (Month, Day, Year) <b>AUG 17 2000</b>	
	32. Registrar's Signature 				33. State Registrar <b>State Registrar</b>				34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	



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State of Maryland / Department of Health and Mental Hygiene

amend item 24a per Phys. G787 9/14/00 yf

## Certificate of Death

Reg. No.

00 27821

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Susan Reynolds Martin</b>				2. Date of Death Month <b>August</b> Day <b>9</b> Year <b>2000</b>		3. Time of Death <b>7:00 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>206 McKendree Ave.</b>				4b. City, Town, or Location of Death <b>Annapolis</b>		4c. County of Death <b>Anne Arundel</b>	
Funeral Director	5. Social Security Number <b>132-32-3117</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>58</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Sept. 16, 1941</b>	
	9. Birthplace (State or Foreign Country) <b>Ohio</b>		10. Usual Residence of Decedent 10e. State <b>MD</b> 10b. County <b>Anne Arundel</b> 10c. City, Town or Location <b>Annapolis</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number <b>206 McKendree Ave.</b>		10f. Zip Code <b>21401</b>		10g. Citizen of What Country? <b>USA</b>				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Teacher</b>		16b. Kind of Business/Industry <b>Public Schools</b>				
17. Father's Name (First, Middle, Last) <b>Donald P. Reynolds</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Martha Lok</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Joseph Martin / husband</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>206 McKendree Ave. Annapolis, MD. 21401</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Ft. Lincoln Crematory</b>		20c. Location - City or Town, State <b>8-11-00 Brentwood, MD.</b>		
21. Signature of Funeral Service Licensee <b>E. Brian Powell</b>				22. Name and Address of Facility <b>John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. Presumed Ventricular aneurysm</b> Due to (or as a consequence of): <b>b. Hypertension</b> Due to (or as a consequence of): <b>c. CAD</b> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>d.</b>								
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <b>Michael J. LaPenta</b>				29c. License number <b>D21438</b>		29d. Date signed (Month, Day, Year) <b>Aug 10, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Michael J. LaPenta, M.D. 600 Ridgely Ave. Suite 120 Annapolis, MD. 21401</b>								
31. Date filed (Month, Day, Year) <b>AUG 14 2000</b>		32. Registrar's Signature <b>B. Sparks</b>						

ORIGINAL

Page 1 of 5000

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 00 27822

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Frank Isaiah Peters, Jr.				2. Date of Death Month Day Year Aug 13 2000		3. Time of Death 14:07		
	4a. Facility Name (If not institution, give street and number) 414 Dembytown Rd				4b. City, Town, or Location of Death Joppa		4c. County of Death Harford		
Funeral Director	5. Social Security Number 220-50-1710		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 51 Yrs.		8. Date of Birth (Month, Day, Year) June 4, 1949		
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Harford		10c. City, Town or Location Joppa		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 414 Dembytown Road		10f. Zip Code 21085		10g. Citizen of What Country? USA	
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10		College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Custodian		16b. Kind of Business/Industry Public School			
17. Father's Name (First, Middle, Last) Frank Isaiah Peters, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Lillian Catherine Chase					
19a. Informant's Name/Relationship (Type, Print) Maurice E. Peters / Brother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 512 Dembytown Road, Joppa, Maryland 21085					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Highview Memorial Gardens 8-17-00 Fallston, Maryland				20c. Location - City or Town, State	
21. Signature of Funeral Service Licensee Charles A. Emery Jr.				22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland					
23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death	
a. MULTIPLE SCLEROSIS Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.									
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
				28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier DME				29c. License number OCME	
				29d. Data signed (Month, Day, Year) Aug 13 2000					
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) GPRABHU MD 728 BELAIR RD BELAIR MD 21014									
31. Date filed (Month, Day, Year) AUG 16 2000				32. Registrar's Signature B. Sparks					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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00-08-16 P03:16 IN

00-08-16 P03:24 OUT



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27823

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Evelyn Virginia Pollitt</b>				2. Date of Death Month <b>August</b> Day <b>23</b> Year <b>2000</b>		3. Time of Death <b>0520</b>		
	4a. Facility Name (If not institution, give street and number) <b>Snow Hill Nursing and Rehabilitation Center</b>				4b. City, Town, or Location of Death <b>Snow Hill</b>		4c. County of Death <b>Worcester</b>		
Funeral Director	5. Social Security Number <b>230-34-6911</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>91</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>April 16, 1909 MD</b>		
	10a. State <b>MD</b>		10b. County <b>Worcester</b>		10c. City, Town or Location <b>Snow Hill</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number <b>7316 Whiton Road</b>		10f. Zip Code <b>21863</b>		10g. Citizen of What Country? <b>US</b>					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (14 or 5+) <b>College</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>					
17. Father's Name (First, Middle, Last) <b>George L. Tarr</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Clara Hudson</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Rosine P. Shockley (daughter)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7316 Whiton Road, Snow Hill, Md. 21863</b>					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Union Cemetery</b>		Date <b>8-26-00</b>		20c. Location - City or Town, State <b>Greenbackville, Va.</b>			
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>The Burbage Funeral Home 208 W. Federal St., Snow Hill, Md. 21863</b>					
23a. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>Acute Large Left Nonhemorrhagic Infarct</b> Due to (or as a consequence of): b. <b>Left Middle Cerebral Artery Occlusion</b> Due to (or as a consequence of): c. <b>Cerebral Artery Atherosclerosis</b> Due to (or as a consequence of): d. <b>Generalized Atherosclerosis</b>		Approximate Interval Between Onset and Death <b>4 days</b> <b>4 days</b>							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Large Left Subdural Hematoma, chronic</b> <b>Essential Hypertension</b> <b>Senile Dementia</b>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <b>D29505</b>		29d. Date signed (Month, Day, Year) <b>8-23-2000</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>GREGORIO M. BELLOSO, M.D., 5302 CHINABERRY DRIVE, SALISBURY, MD 21801</b>									
31. Date filed (Month, Day, Year) <b>AUG 24 2000</b>		32. Registrar's Signature <i>[Signature]</i>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27824

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Zelma Nora Reese				2. Date of Death Month Day Year August 17, 2000				3. Time of Death 8:30 PM		
	4a. Facility Name (If not institution, give street and number) Carroll County General Hospital				4b. City, Town, or Location of Death Westminster				4c. County of Death Carroll		
Funeral Director	5. Social Security Number 216-36-6436		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 88 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 2 1912		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent				10c. City, Town or Location Westminster		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
10a. State Maryland		10b. County Carroll		10e. Street and Number 99 Charles St. APT C				10f. Zip Code 21157		10g. Citizen of What Country? United States	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 3rd College (1-4 or 5+) _____				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Her Home			
17. Father's Name (First, Middle, Last) Samuel Fritz					18. Mother's Name (First, Middle, Maiden Surname) Alice Nail						
19a. Informant's Name/Relationship (Type, Print) Robert Runkles (Son)					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6880 Watersville, Rd. Mt. Airy, MD 21771						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Prospect Cemetery		20c. Date 8/21/2000		20d. Location - City or Town, State Mt. Airy, MD				
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility Burrier-Queen Funeral Directors, PA 1212 West Old Liberty Rd. Winfield, MD 21784						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. VENTRICULAR ASYSTOLE Due to (or as a consequence of): b. Acute myocardial infarction Due to (or as a consequence of): c. Respiratory failure Due to (or as a consequence of): d. _____  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death over 4 hours 24 hours	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Theophylline toxicity										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier 					29c. License number D0018200		29d. Date signed (Month, Day, Year) 8/17/00				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHITRACHEDU NAGANNA MD 700 APOLE RD WESTMINSTER MD 21157											
State Registrar		31. Date filed (Month, Day, Year) AUG 21 2000		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27825

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARY ANN ROSSO

2. Date of Death

Month Day Year  
Aug. 15, 2000

3. Time of Death

9:20 AM

4a. Facility Name (If not institution, give street and number)

SALISBURY CENTER: GENESIS ELDERCARE

4b. City, Town, or Location of Death

SALISBURY, MD.

4c. County of Death

WICOMICO

Funeral  
Director

5. Social Security Number

048-01-1723

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
SEPT. 6, 1912

9. Birthplace (State or Foreign Country)

CONNECTICUT

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

WICOMICO

10c. City, Town or Location

SALISBURY

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6102 AYRSHIRE DRIVE

10f. Zip Code

21801

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

FRANK SPETA

18. Mother's Name (First, Middle, Maiden Surname)

UNKNOWN

19a. Informant's Name/Relationship (Type, Print)

JAMES D. ROSSO/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

27167 PATRIOT DRIVE, SALISBURY, MARYLAND 21801

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

ST. MICHAEL'S CEMETERY

Date

8/18/00

20c. Location - City or Town, State

STRATFORD, CONNECTICUT

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

ZELLER FUNERAL HOME, P. O. BOX 3171,  
1212 OLD OCEAN CITY ROAD, SALISBURY, MD 2180223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. *Metastatic Cancer of Unknown Primary*  
Due to (or as a consequence of):Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death*1 Month*

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of injury

(Month, Day Year)

28b. Time of  
injury

M

28c. Injury at  
work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D39813

29d. Date signed (Month, Day, Year)

8/15/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL ATKINS, M.D., 1104 HEALTHWAY DR., SALISBURY, MD 21804

State  
Registrar

31. Date filed (Month, Day, Year)

AUG 16 2000

32. Registrar's Signature

ORIGINAL

100,000,000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27826

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Ruth Edith Stover-Anderson

2. Date of Death

August

Day

14

Year

2000

3. Time of Death

9:00pm

4a. Facility Name (If not Institution, give street and number)

4104 Conowingo Road Lot 11

4b. City, Town, or Location of Death

Darlinton

4c. County of Death

Harford

5. Social Security Number

191-14-4589

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

09/08/1906

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Darlinton

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

10e. Street and Number

4104 Conowingo Road Lot 11

10f. Zip Code

21034

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16e. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Book Keeper

16b. Kind of Business/Industry

Printing Company

17. Father's Name (First, Middle, Last)

Joseph Histan Stover

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Buckman

19a. Informant's Name/Relationship (Type, Print)

Lewis James Anderson- Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1407 Crestway Ct., Fallston, MD 21047

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Carversville Cemetery

Date

8/19/00

20c. Location - City or Town, State

Solebury Twnshp., PA

21. Signature of Funeral Service Licensee

Dukine M. Smith

22. Name and Address of Facility

Mitchell-Smith Funeral Home, P.A.  
123 S. Washington, Havre de Grace, MD 21078

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Dementia

a. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease.

Renal Insufficiency.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Kevin Lynch

29c. License number

D35012

29d. Date signed (Month, Day, Year)

August 16, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. Kevin Lynch MD.

2 North Ave.

Bel Air, Md. 21014

31. Date filed (Month, Day, Year)

AUG 16 2000

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27827

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Una Irene Stringer				2. Date of Death Month Day Year August 10 2000				3. Time of Death 304PM	
	4a. Facility Name (If not institution, give street and number) Fallston General Hospital				4b. City, Town, or Location of Death Fallston				4c. County of Death Harford	
Funeral Director	5. Social Security Number 430-16-6887		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 89 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 25, 1910		9. Birthplace (State or Foreign Country) Arkansas	
	Usual Residence of Decedent									
10a. State Maryland		10b. County Harford		10c. City, Town or Location Abingdon				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 3709 Longley Road				10f. Zip Code 21009		10g. Citizen of What Country? USA				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Hairdresser				16b. Kind of Business/Industry Hair Care		
17. Father's Name (First, Middle, Last) Hubert Reece Downs					18. Mother's Name (First, Middle, Maiden Surname) Dora Mary Cook					
19a. Informant's Name/Relationship (Type, Print) Ronald P. Stringer/Son					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 900 Wiseburg Road, White Hall, MD 21161					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Harford Memorial Gardens 8/14/00		20c. Location - City or Town, State Aberdeen, MD				
21. Signature of Funeral Service Licensee Charles A. Imge					22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009					
23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pneumonia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Respiratory Failure Anemia Hypoxia Polyarthrosis										Approximate Interval Between Onset and Death 2 weeks
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Respiratory Failure Anemia Hypoxia Polyarthrosis										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier Mirza A-BAG MD				29c. License number D43115				29d. Date signed (Month, Day, Year) 8-11-00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 615 S. Union Ave, HDG, MD 21078										
31. Date filed (Month, Day, Year) AUG 15 2000				32. Registrar's Signature B. Smith						

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27828

Amended Item # 1,23A PERPHYG788 10/10/2000 EW

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>JOANNA</u> Joanne GARDNER SAVAGE		2. Date of Death Month Day Year August 5, 2000		3. Time of Death 11:08 AM
	4e. Facility Name (If not institution, give street and number) 209 Beaver Dam Drive		4b. City, Town, or Location of Death Salisbury		4c. County of Death Wicomico
Funeral Director	5. Social Security Number 227-34-3168	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 69 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) February 2, 1931		9. Birthplace (State or Foreign Country) Virginia		
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State Maryland		10b. County Wicomico
	10c. City, Town or Location Salisbury		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 209 Beaver Dam Dr.		10f. Zip Code 21804		10g. Citizen of What Country? USA
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: WHITE		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 12		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER
	17. Father's Name (First, Middle, Last) MILTON REID GARDNER		18. Mother's Name (First, Middle, Maiden Surname) RUTH MARTIN		
	19e. Informant's Name/Relationship (Type, Print) DON SAVAGE, JR.		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 209 BEAVER DAM DR., SALISBURY, MD. 21804		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) FAIRVIEW LAWN CEMETERY		20c. Location - City or Town, State ONANCOCK, VIRGINIA
	21. Signature of Funeral Service Licensee <i>John J. Williams</i>		22. Name and Address of Facility WILLIAMS-PARKSLEY FUNERAL HOME 25046 PARKSLEY RD., PARKSLEY, VA. 23421		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) METASTATIC LUNG CANCER a. <del>METASTATIC CANCER</del> Due to (or as a consequence of): b. <del>...</del> Due to (or as a consequence of): c. <del>...</del> Due to (or as a consequence of): d. <del>...</del> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death 3 MONTHS		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MULTIPLE SCLEROSIS		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <i>A. Hall M.D.</i>		29c. License number D 29168		29d. Date signed (Month, Day, Year) 8/15/00	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBERT ALLEN M.D., 100 POWER ST, SALISBURY, MARYLAND 21804					
State Registrar	31. Date filed (Month, Day, Year) AUG 23 2000		32. Registrar's Signature <i>B. Sparks</i>		

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27829

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Michael Angelo Scalzo</b>				2. Date of Death Month <b>August</b> Day <b>20</b> Year <b>2000</b>		3. Time of Death <b>11:05 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>154 Captains Quarters Drive</b>				4b. City, Town, or Location of Death <b>Ocean City</b>		4c. County of Death <b>Worcester</b>	
Funeral Director	5. Social Security Number <b>094-16-3107</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>77</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>June 28, 1923</b>		9. Birthplace (State or Foreign Country) <b>NY</b>
	Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>Worcester</b>		10c. City, Town or Location <b>Ocean City</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>154 Captains Quarters Drive</b>				10f. Zip Code <b>21842</b>		10g. Citizen of What Country? <b>US</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>5+</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Aeronautical Engineer</b>		16b. Kind of Business/Industry <b>Self Employed</b>		
17. Father's Name (First, Middle, Last) <b>Genaro Scalzo</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Emma Serina</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Dorothy Scalzo</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>154 Captains Quarters Drive, Ocean City, Md. 21842</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cape Henlopen Crematory 8-21-00 Frankford, Delaware</b>		20c. Location - City or Town, State				
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>The Burbage Funeral Home 108 William St., Berlin, Md. 21811</b>				
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
Immediate Cause (Final disease or condition resulting in death)		a. <b>LUNG CANCER</b>				Approximate Interval Between Onset and Death <b>3 months</b>		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. Due to (or as a consequence of):						
		c. Due to (or as a consequence of):						
		d. Due to (or as a consequence of):						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <b>DO47676</b>		29d. Date signed (Month, Day, Year) <b>8/21/00</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Bsher A. Touleimat, M.D. 9733 Healthway Dr., Berlin, Md. 21811</b>								
31. Date filed (Month, Day, Year) <b>AUG 21 2000</b>				32. Registrar's Signature <i>[Signature]</i>				

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEMS: #26 PER MEO G787 9-16-00

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27830

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ROY MICHAEL SWANSON</b>				2. Date of Death Month Day Year <b>AUGUST 21 2000</b>		3. Time of Death <b>1:07 PM</b>
	4a. Facility Name (If not institution, give street and number) <b>PRINCE GEORGES HOSPITAL</b>				4b. City, Town, or Location of Death <b>CHEVERLY</b>		4c. County of Death <b>PRINCE GEORGES</b>
Funeral Director	5. Social Security Number <b>578-96-6592</b>	6. Sex <b>1 M 2 F</b>	7. Age (In yrs. last birthday) <b>24</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>JAN. 20, 1976</b>	
	9. Birthplace (State or Foreign Country) <b>WASHINGTON, D.C.</b>						
Usual Residence of Decedent							
10a. State <b>MARYLAND</b>		10b. County <b>CHARLES</b>		10c. City, Town or Location <b>NEWBURG</b>		10d. Inside City Limits <b>1 Yes 2 No</b>	
10e. Street and Number <b>11670 PERRY BRANCH ROAD</b>				10f. Zip Code <b>20664</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <b>1 Never Married 2 Married</b> <b>3 Widowed 4 Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 Yes 2 No</b> If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 Yes 2 No Specify:</b>		14. Race - American Indian, Black, White, etc. <b>Specify: WHITE</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Siding Installer</b>		16b. Kind of Business/Industry <b>Construction</b>	
17. Father's Name (First, Middle, Last) <b>REGINALD S. SWANSON</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>BARBARA J. KIRBY</b>			
19a. Informant's Name/Relationship (Type, Print) <b>REGINALD S. SWANSON/FATHER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5324 SWEETWATER DRIVE, WEST RIVER, MARYLAND 20778</b>			
20a. Method of Disposition <b>1 Burial 2 Cremation 3 Removal from State</b> <b>4 Donation 5 Other (Specify)</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>NO. MYRTLE BEACH MEM. GARDENS</b>		20c. Location - City or Town, State <b>NO. MYRTLE BEACH, SC</b>		20d. Date <b>08-26-2000</b>	
21. Signature of Funeral Service Licensee <b>JOHN P. KNISLEY</b> MO1164				22. Name and Address of Facility <b>THE HUNTT FUNERAL HOME, INC.</b> <b>P.O. BOX 156, WALDORF, MARYLAND 20604</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. HEAD INJURIES</b> Due to (or as a consequence of):  <b>b.</b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23b. Did tobacco use contribute to the cause of death? <b>1 Yes 2 No 3 Probably 4 Unknown</b>						24a. Was an autopsy performed? <b>1 Yes 2 No</b>	
24b. Were autopsy findings available prior to completion of cause of death? <b>1 Yes 2 No</b>						25. Was case referred to medical examiner? <b>1 Yes 2 No</b>	
26. Place of Death (Check only one) Hospital: <b>1 Inpatient 2 ER/Outpatient 3 Other</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>				27. Manner of Death <b>1 Natural 2 Accident 3 Suicide 4 Homicide</b> <b>5 Pending investigation 6 Could not be determined</b>			
28a. Date of Injury (Month, Day Year) <b>08-18-2000</b>		28b. Time of Injury <b>2320 M</b>		28c. Injury at Work? <b>1 Yes 2 No</b>		28d. Describe how injury occurred <b>Passenger on motorcycle Ejected and impacted fixed object</b>	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Street</b>				28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>Charles County, MD</b>			
29a. Certifier (Check only one) <b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>							
29b. Signature and title of certifier <b>J.M. [Signature] For</b>				29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JOSEPH PESTANER M.D. 111 Penn Street, Baltimore, Maryland 21201</b>							
31. Date filed (Month, Day, Year) <b>AUG 23 2000</b>				32. Registrar's Signature <b>[Signature]</b>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27831

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

OTTIS GERTRAUDE BELL SHAFFER

2. Date of Death

Month Day Year  
AUG. 7, 2000

3. Time of Death

7:15 PM

4a. Facility Name (If not institution, give street and number)

SALISBURY CENTER; GENESIS ELDERCARE

4b. City, Town, or Location of Death

SALISBURY, MD.

4c. County of Death

WICOMICO

Funeral  
Director

5. Social Security Number

219-05-3737

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

95 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

7-13-05

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD.

10b. County

WICOMICO

10c. City, Town or Location

SALISBURY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1504 RIVERSIDE DRIVE

10f. Zip Code

21801

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

DOMESTIC WORK

16b. Kind of Business/Industry

SELF EMPLOYED

17. Father's Name (First, Middle, Last)

LEVI HOLBROOK

18. Mother's Name (First, Middle, Maiden Surname)

MAGGIE PETERS

19a. Informant's Name/Relationship (Type, Print)

SHELIA BELL/GRAND-DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

27513-WALLER RD. SALISBURY, MD. 21801

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

SPRINGHILL CEMETARY

Data

8-10-2000 HEBRON MD.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

BENNIE SMITH F.H.  
917-W. ISABELLA ST. SALISBURY, MD. 21801

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Advanced Breast Cancer METASTATIC

Due to (or as a consequence of):

b. And

Due to (or as a consequence of):

c. END Stage ALZHEIMER'S Disease

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Many years

a a

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D-39813

29d. Date signed (Month, Day, Year)

8/6/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL ATKINS, M.D., 1104 HEALTHWAY DR., SALISBURY, MD 21804

State  
Registrar

31. Date filed (Month, Day, Year)

AUG 10 2000

32. Registrar's Signature

ORIGINAL

OTTIS SHAFFER  
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

pages. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified as

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27832

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARGARET B. ULRICH

2. Date of Death  
Month Day Year

AUGUST 15, 2000

3. Time of Death

0850

4a. Facility Name (If not institution, give street and number)

14 LESLIE MEWS

4b. City, Town, or Location of Death

OCEAN PINES

4c. County of Death

WORCESTER

Funeral  
Director

5. Social Security Number

064-05-4227

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

10-25-12

9. Birthplace (State or Foreign Country)

NY

Usual Residence of Decedent

10a. State

NY

10b. County

QUEENS

10c. City, Town or Location

LONG ISLAND CITY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

32-30 41ST STREET

10f. Zip Code

11103

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

OFFICE WORKER

16b. Kind of Business/Industry

ACCOUNTING

17. Father's Name (First, Middle, Last)

PATRICK BREEN

18. Mother's Name (First, Middle, Maiden Surname)

MARY ANN LYNCH

19a. Informant's Name/Relationship (Type, Print)

EILEEN SMITH DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14 LESLIE MEWS OCEAN PINES, MD., 21811

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ST. CHARLES CEMETERY

Date

8-18

20c. Location - City or Town, State

SUFFOLK CO., NY

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

ULLRICH FUNERAL HOME BERLIN, MD.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Lung CA.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)

29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. M. 2000, MD 9733 NEARBY DR BERLIN MD 21811

State  
Registrar

31. Date filed (Month, Day, Year)

AUG 16 2000

32. Registrar's Signature

Geneva B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27833

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>ORPA MAY WALKER</b>				2. Date of Death Month Day Year <b>AUGUST 17, 2000</b>		3. Time of Death <b>0315</b>	
4a. Facility Name (If not institution, give street and number) <b>ATLANTIC GENERAL HOSPITAL</b>				4b. City, Town, or Location of Death <b>BERLIN</b>		4c. County of Death <b>WORCESTER</b>	
5. Social Security Number <b>579-32-8373</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>92</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>6-17-08</b>	
9. Birthplace (State or Foreign Country) <b>CA.</b>		10a. State <b>MD.</b>		10b. County <b>WORCESTER</b>		10c. City, Town or Location <b>OCEAN PINES</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>23 PINTAIL DRIVE</b>		10f. Zip Code <b>21811</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>REGISTERED NURSE</b>		16b. Kind of Business/Industry <b>HEALTH CARE</b>		17. Father's Name (First, Middle, Last) <b>ALTON LIEBSHER</b>	
18. Mother's Name (First, Middle, Maiden Surname) <b>ETHEL SCOGGINS</b>		19a. Informant's Name/Relationship (Type, Print) <b>MARGARET J. GARNER DAUGHTER</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>23 PINTAIL DR., OCEAN PINES, MD., 21811</b>		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
20b. Place of Disposition (Name of cemetery, crematory or other place) <b>SALISBURY CREMATORY</b>		20c. Location - City or Town, State <b>8-18 SALISBURY, MD.</b>		21. Signature of Funeral Service Licensee <i>John J. Ullrich</i>		22. Name and Address of Facility <b>ULLRICH FUNERAL HOME BERLIN, MD., 21811</b>	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <i>Respiratory arrest</i> Due to (or as a consequence of): b. <i>Respiratory failure</i> Due to (or as a consequence of): c. <i>Sepsis</i> Due to (or as a consequence of): d. <i>Acute Myelogenous Leukemia</i>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined			
28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i>	
29c. License number <b>D-0084221</b>		29d. Date signed (Month, Day, Year) <b>8/17/00</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>J.M. Stevens, 18 mason Dixon chip ave selbyville DE 19475</b>		31. Date filed (Month, Day, Year) <b>8 21 2000</b>	
32. Registrar's Signature <i>[Signature]</i>		33. Registrar's Title <b>B. Jones</b>		34. Registrar's Name <b>B. Jones</b>		35. Registrar's Address <b>B. Jones</b>	

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

Physician  
/Medical  
Examiner

Funeral  
Director

0315 8/17/2000

Physician  
/Medical  
Examiner

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/Medical  
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Funeral  
Director

0315 8/17/2000

Physician

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27834

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Josephine A. Auffarth</u>		2. Date of Death Month <u>August</u> Day <u>31</u> Year <u>2000</u>		3. Time of Death <u>2243</u>
	4a. Facility Name (If not institution, give street and number) <u>The Johns Hopkins Hospital</u>		4b. City, Town, or Location of Death <u>Baltimore</u>		4c. County of Death
Funeral Director	5. Social Security Number <u>213-01-5715</u>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <u>85</u> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <u>3/6/1915</u>		9. Birthplace (State or Foreign Country) <u>Massachusetts</u>		
Usual Residence of Decedent					
10a. State <u>MD</u>		10b. County <u>n/a</u>		10c. City, Town or Location <u>Baltimore</u>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number <u>612 N. Clinton Street</u>			10f. Zip Code <u>21205</u>		10g. Citizen of What Country? <u>USA</u>
11. Mental Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <u>White</u>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>8th</u>		College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Homemaker</u>	
16b. Kind of Business/Industry <u>In own home</u>					
17. Father's Name (First, Middle, Last) <u>Emidio Schiavi</u>			18. Mother's Name (First, Middle, Maiden Surname) <u>Maria Olivieri</u>		
19a. Informant's Name/Relationship (Type, Print) <u>husband</u> <u>George Auffarth</u>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>612 N. Clinton Street, Baltimore, Maryland 21205</u>		
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <u>entombment</u>		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Lorraine Park</u>		20c. Location - City or Town, State <u>9/5/2000 Baltimore, Maryland</u>	
21. Signature of Funeral Service Licensee <u>Joseph N. Zannino Jr.</u>			22. Name and Address of Facility <u>263 South Conkling Street, Baltimore, Maryland 21224</u>		
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)					
e. <u>Pericardial tamponade</u>					
Due to (or as a consequence of):					
b. <u>Hemorrhagic Pericarditis</u>					
Due to (or as a consequence of):					
c.					
Due to (or as a consequence of):					
d.					
Approximate Interval Between Onset and Death <u>20 minutes</u> <u>45 minutes</u>					
Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Hypertension</u> <u>Coronary artery disease</u>					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <u>M</u>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <u>Dr. Elferlein MD</u>		29c. License number <u>RES 000</u>		29d. Date signed (Month, Day, Year) <u>August 31, 00</u>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Ron Elferlein Johns Hopkins Hospital 600 N. Wolfe St.</u>					
31. Date filed (Month, Day, Year) <u>SEP 5 2000</u>		32. Registrar's Signature <u>[Signature]</u>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27835

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Rhea E. Brayboy		2. Date of Death Month Day Year Aug. 30, 2000		3. Time of Death 1700
	4a. Facility Name (If not institution, give street and number) Good Samaritan Hospital		4b. City, Town, or Location of Death Baltimore		4c. County of Death NA
Funeral Director	5. Social Security Number 219-52-4940	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 51 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) 07-18-48		9. Birthplace (State or Foreign Country) MD		
Usual Residence of Decedent					
10a. State MD		10b. County NA		10c. City, Town or Location Baltimore	
10e. Street and Number 524 Chateau Avenue		10f. Zip Code 21212		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Grade 1yr.			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk		16b. Kind of Business/Industry State of Maryland Dept. of Soc. Service			
17. Father's Name (First, Middle, Last) George June			18. Mother's Name (First, Middle, Maiden Surname) Susie Webster		
19a. Informant's Name/Relationship (Type, Print) Eugene Brayboy			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 524 Chateau Avenue Baltimore, Maryland 21212		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) King Mem. Pk. Cem.		20c. Location - City or Town, State 09-06-2000 Randallstown, MD	
21. Signature of Funeral Service Licensee Gabrielle Cook		22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Myocardial Infarction Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hypertension					
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier Betsy A. Fay MD		29c. License number 033220		29d. Date signed (Month, Day, Year) 9/1/00	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Betsy A. Fay 3730 Falls Rd. Balto. Md. 21211					
31. Date filed (Month, Day, Year) SEP 5 2000		32. Registrar's Signature B. Sparks			

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27836

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HELEN BOMBERG</b>		2. Date of Death Month <b>Sept</b> Day <b>2</b> Year <b>2000</b>		3. Time of Death <b>9:50 PM</b>
	4a. Facility Name (If not institution, give street and number) <b>GOOD SAMARITAN HOSPITAL</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>BALTIMORE</b>
Funeral Director	5. Social Security Number <b>213-36-0072</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>85</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>Jan. 9, 1915</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>
	10c. City, Town or Location <b>Middle River</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>15 Right Aileron Street</b>		10f. Zip Code <b>21220</b>		10g. Citizen of What Country? <b>U.S.A.</b>
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>House wife</b>		16. Kind of Business/Industry <b>Own Home</b>
	17. Father's Name (First, Middle, Last) <b>Frederick Baum</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Marie Cummings</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Richard Bomberg (son)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>106 West Kingston Park Lane, Baltimore, Md. 21220</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Holly Hill Mem. Gardens</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Bruzdinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221</b>		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. SEPSIS</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>		Approximate Interval Between Onset and Death <b>21 week</b>		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>N. D. M.D.</b>		29c. License number <b>P 11902</b>	
29d. Date signed (Month, Day, Year) <b>Sept 2, 2000</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>NOUHAD DAMAJ GOOD SAMARITAN HOSPITAL 5001 KENYARD BLVD BALTIMORE MD 21239</b>			
31. Date filed (Month, Day, Year) <b>SEP 5 2000</b>		32. Registrar's Signature 			



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State of Maryland / Department of Health and Mental Hygiene 00 27837

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Julia F Brown</i>				2. Date of Death Month <i>August</i> Day <i>31</i> Year <i>2000</i>				3. Time of Death <i>1:10 AM</i>	
	4a. Facility Name (If not institution, give street and number) <i>Good Samaritan Nursing Center</i>				4b. City, Town, or Location of Death <i>Baltimore</i>				4c. County of Death <i>N/A</i>	
Funeral Director	5. Social Security Number <i>216-14-0352</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>99</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>Dec. 31, 1900</i>		9. Birthplace (State or Foreign Country) <i>Maryland</i>	
	Usual Residence of Decedent				10a. State <i>Maryland</i>		10b. County <i>N/A</i>		10c. City, Town or Location <i>Baltimore</i>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number <i>2401 Harlem Ave. 2nd Floor</i>				10f. Zip Code <i>21216</i>	
	10g. Citizen of What Country? <i>USA</i>				11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <i>Negro</i>				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>2</i>	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Homemaker</i>				16b. Kind of Business/Industry <i>Own Home</i>				17. Father's Name (First, Middle, Last) <i>Lucian Brown</i>	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) <i>Julia Wood</i>				19a. Informant's Name/Relationship (Type, Print) <i>Mrs. Geraldine Gray (Niece)</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>825 Wicklow Rd. Balto. Md. 21229</i>	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Mt. Auburn</i>				20c. Location - City or Town, State <i>Balto. Md.</i>	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>Joseph L. Russ</i>				22. Name and Address of Facility <i>Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216</i>				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <i>a. Myocardial infarction</i> Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>b.  c.  d.</i> Due to (or as a consequence of):  Approximate Interval Between Onset and Death <i>less than hour</i>	
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day, Year)				28b. Time of Injury <i>M</i>				28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>Shresh Tripathi</i>				29c. License number <i>D 30661</i>	
To Be Completed by Physician/Medical Examiner	29d. Date signed (Month, Day, Year) <i>September 1st 2000</i>				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>SIREESH TRIPURANENI 1601 East Belvedere, Baltimore, Md - 21239</i>				31. Date filed (Month, Day, Year) <i>SEP 5 2000</i>	
	32. Registrar's Signature <i>[Signature]</i>				33. State Registrar <i>[Signature]</i>				34. State Registrar <i>[Signature]</i>	

ORIGINAL





ADH  
ANDRE BLUE  
00-4994-510

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State of Maryland / Department of Health and Mental Hygiene

amend item 23a,27,28a,b,c,d,e,f per me G787 9/26/00 yf Certificate of Death

Reg. No. 00 27838

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Andre Alexander Blue</b>				2. Date of Death Month Day Year <b>SEPTEMBER 1, 2000</b>		3. Time of Death <b>2229 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>MERCY HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE CITY</b>		4c. County of Death <b>N/A</b>		
Funeral Director	5. Social Security Number <b>217-84-4696</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>37</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Sept. 26, 1962</b>	9. Birthplace (State or Foreign Country) <b>New Jersey</b>	
	Usual Residence of Decedent								
10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>3007 Presstman St.</b>		10f. Zip Code <b>21216</b>		10g. Citizen of What Country? <b>USA</b>					
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Afro American</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Medical Technician U.S. Government</b>		16b. Kind of Business/Industry			
17. Father's Name (First, Middle, Last) <b>Sherman Blue</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Shelia Jones</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Rev. Adah Jones Grandmother</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3007 Presstman St. Balto, Md. 21216</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Garrison Forest</b>		Date <b>9/8/2000</b>		20c. Location - City or Town, State <b>Owings Mills, Md.</b>			
21. Signature of Funeral Service Licensee <b>Joseph L. Russ</b>				22. Name and Address of Facility <b>Joseph L. Russ Funeral Home 2222 W. North Ave. Balto, Md. 21216</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>HEAD INJURIES WITH COMPLICATIONS</b> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24e. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>unknown</b>		28b. Time of Injury <b>unknown M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>unknown</b>	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>unknown</b>				28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>unknown</b>					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier <b>Joseph L. Russ</b>				29c. License number <b>OCME</b>		29d. Date signed (Month, Day, Year) <b>SEPTEMBER 2, 2000</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>John Locke 111 Penn Street, Baltimore, Maryland 21201</b>									
State Registrar		31. Date filed (Month, Day, Year) <b>SEP 05 2000</b>		32. Registrar's Signature <b>B. Sparks</b>					



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State of Maryland / Department of Health and Mental Hygiene

00 27839

Amended item38 perFH,23a perPHYG787 9/5/2000 EW

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>BERTHA BRANHAM</b>		2. Date of Death Month Day Year <b>AUGUST 11 2000</b>		3. Time of Death <b>1200 NOON</b>
	4a. Facility Name (If not institution, give street and number) <b>HOWARD COUNTY GENERAL HOSPITAL</b>		4b. City, Town, or Location of Death <b>COLUMBIA</b>		4c. County of Death <b>HOWARD</b>
Funeral Director	5. Social Security Number <b>214-30-6978</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>84</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>July 2, 1920</b>	9. Birthplace (State or Foreign Country) <b>Virginia</b>
	Usual Residence of Decedent				
10a. State <b>Maryland</b>		10b. County <b>Howard</b>		10c. City, Town or Location <b>Columbia</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <b>5430 Waterloo Road</b>		10f. Zip Code <b>21045</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No X If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No X Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>American Indian</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>None</b> College (1-4 or 5+) <b>None</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Waitress</b>		16b. Kind of Business/Industry <b>Restaurant</b>	
17. Father's Name (First, Middle, Last) <b>Hurley Branham</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Ruth Branham</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Barbara Miller Cousin</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3570 Courthouse Drive Apt. #2D Ellicott City, Maryland 21043</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Paul's Cemetery</b>		20c. Location - City or Town, State <b>Monroe, Virginia</b>	
21. Signature of Funeral Service Licensee <b>Timothy S. Hull</b>		22. Name and Address of Facility <b>Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>RESPIRATORY FAILURE</b> <b>RIGHT LUNG MASS</b> Due to (or as a consequence of): <b>RIGHT LUNG MASS, PROBABLE MALIGNANCY</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>HEART FAILURE</b> <b>ARRHYTHMIA</b> <b>CEREBROVASCULAR ACCIDENT</b>		Approximate Interval Between Onset and Death <b>4 MONTHS</b> <b>4 Months</b>			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HEART FAILURE</b> <b>ARRHYTHMIA</b> <b>CEREBROVASCULAR ACCIDENT</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>ASymd</b>		29c. License number <b>D39629</b>	
29d. Date signed (Month, Day, Year) <b>AUGUST 11, 2000</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ALEXANDER SY MD, 10724 LITTLE PATUXENT PARKWAY COLUMBIA MD 21044</b>					
31. Date filed (Month, Day, Year) <b>SEP 5 2000</b>		32. Registrar's Signature <b>B. Sparks</b>			

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 00 27840

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Marie Augusta Burke</b>				2. Date of Death Month <b>September</b> Day <b>1</b> Year <b>2000</b>		3. Time of Death <b>4:45 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Genesis Eldercare</b>				4b. City, Town, or Location of Death <b>Severna Park</b>		4c. County of Death <b>Anne Arundel</b>		
Funeral Director	5. Social Security Number <b>214-03-4107</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>104</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>May 7, 1896</b>		
	9. Birthplace (State or Foreign Country) <b>Baltimore, MD</b>		10a. State <b>MD</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Severna Park</b>		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>112 Avondale Circle</b>		10f. Zip Code <b>21146</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> Collega (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>own home</b>		17. Father's Name (First, Middle, Last) <b>George Bowers</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Pauline Burgemeister</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Doris B. Dunker-daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>112 Avondale Cir., Severna Park, MD 21146</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Moreland Memorial Park</b>		20c. Location - City or Town, State <b>9/5/00 Baltimore, MD</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>William G. Dau</b> <b>Baltimore, Maryland 21214</b> <b>Leonard J. Ruck, Inc. 5305 Harford Rd.</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. DEMENTIA</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.		Approximate Interval Between Onset and Death <b>5 YEARS</b>			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DEMENTIA</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and Title of certifier 		29c. License number <b>D21776</b>		29d. Date signed (Month, Day, Year) <b>SEPTEMBER 1, 2000</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>SURJA MUNDRA MD 3001 S. HANOVER ST BALTIMORE 21225</b>		31. Date filed (Month, Day, Year) <b>SEP 5 2000</b>		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene

00 27841

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary Frances Cochran				2. Date of Death Month Day Year August 31, 2000				3. Time of Death 3:45 PM	
	4a. Facility Name (If not institution, give street and number) 1 Dutton Court				4b. City, Town, or Location of Death Catonsville				4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 232-32-3764		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 74 Yrs.		8. Date of Birth (Month, Day, Year) DEC 15, 1925		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent				10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Catonsville	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 1 Dutton Court				10f. Zip Code 21228	
	10g. Citizen of What Country? USA				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Own Home				17. Father's Name (First, Middle, Last) Paul Overholt	
	18. Mother's Name (First, Middle, Maiden Surname) Fannie Goulden				19a. Informant's Name/Relationship (Type, Print) Howe Preston Cochran/Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 Dutton Court Catonsville, MD 21228	
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory Inc.				20c. Location - City or Town, State 9-1-00 Baltimore, MD	
	21. Signature of Funeral Service Licensee Thomas Gregor				22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Arrhythmia Due to (or as a consequence of): b. Myocardial Infarction Due to (or as a consequence of): c. Due to (or as a consequence of): d.	
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)				27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day Year)				28b. Time of Injury M				28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
State Registrar	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Thomas J. [Signature]				29c. License number 051811	
	29d. Date signed (Month, Day, Year) September 1, 2000				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1120 N. Rolling Rd Baltimore, MD 21228				31. Date filed (Month, Day, Year) SEP 5 2000	
	32. Registrar's Signature [Signature]				33. Registrar's Signature [Signature]				34. Registrar's Signature [Signature]	

ORIGINAL



00-4970-510

GEORGE

CONOVER

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

AMEND ITEM #11 PER COURT ORDER G805 3-28-02 TAB  
State of Maryland / Department of Health and Mental Hygiene

G787 9/27/00  
amend item 23a, pt II, 27, 28a, b, c, d, e, f per me yf **Certificate of Death**

Reg. No.

00 27842

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

George Michael Conover

2. Date of Death

Month

Day

Year

AUGUST

31, 2000

3. Time of Death

7:42P.M.

4e. Facility Name (If not institution, give street and number)

3503 BONFIELD ROAD

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

212-58-2088

6. Sex

M ☒ F

7. Age (In yrs. last birthday)

46

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

SEPT 24, 1953

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

606 Maiden Choice Lane

10f. Zip Code

21228

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Nurse

16b. Kind of Business/Industry

Hospital

17. Father's Name (First, Middle, Last)

George Quentin Conover

18. Mother's Name (First, Middle, Maiden Surname)

Mary I. Kershaw

19a. Informant's Name/Relationship (Type, Print)

Mary Isabelle Conover/mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

606 Maiden Choice Lane Catonsville, MD 21228

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Metro Crematory, Inc.

Date

9/1/00

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Dawn F. McDonald

22. Name and Address of Facility

Cremation Society of Maryland, Inc.

299 Frederick Road Baltimore, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. ACUTE NARCOTIC INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DEPRESSION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) SCENE

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☒ Could not be determined

28a. Date of Injury

(Month, Day Year)

found: 8/31/00

28b. Time of

injury

unknown M

28c. Injury et

Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

unknown

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

found: home

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)3503 Bonfield Road,  
Baltimore City, Md.29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dennis Chuterma

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

SEPTEMBER 1, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dennis Chuterma

111 Penn Street, Baltimore, Maryland 21201

State  
Registrar

31. Date filed (Month, Day, Year)

SEP 5 2000

32. Registrar's Signature

Dennis Chuterma

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
202-358-2000.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

10/11/1964

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State of Maryland / Department of Health and Mental Hygiene 00 27843

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LEONA COOPER</b>		2. Date of Death Month <b>SEPT</b> Day <b>1<sup>st</sup></b> Year <b>2000</b>		3. Time of Death <b>23:23</b>
	4a. Facility Name (If not institution, give street and number) <b>SR FALLSTON GENERAL HOSPITAL</b>		4b. City, Town, or Location of Death <b>FALLSTON</b>		4c. County of Death <b>HARFORD</b>
Funeral Director	5. Social Security Number <b>227-22-7374</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>78</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>July 2 1922</b>	9. Birthplace (State or Foreign Country) <b>West Virginia</b>
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State <b>Md.</b>	10b. County <b>Harford</b>	10c. City, Town or Location <b>Jarrettsville</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <b>4041 Security Lane</b>		10f. Zip Code <b>21084</b>		10g. Citizen of What Country? <b>USA</b>
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>Waitress</b>		
	16. Kind of Business/Industry <b>Food Service</b>		17. Father's Name (First, Middle, Last) <b>Nathanial Wilkins</b>		
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) <b>Cora Belle Wilson</b>		19a. Informant's Name/Relationship (Type, Print) <b>Mrs. Cyndi Fitzhugh/DTR</b>		
	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4041 Security Ln. Jarrettsville, Md. 21084</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		
	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Dulaney Valley Cem.</b>		20c. Date <b>9-5-00</b>		20d. Location - City or Town, State <b>Timonium, Md.</b>
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204</b>		
	23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>ASCVD</b> Due to (or as a consequence of): a. _____ b. _____ c. _____ d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HYPERTENSION</b>					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined					
28a. Date of Injury (Month, Day, Year) <b>SEP 05 2000</b>					
28b. Time of Injury <b>M</b>					
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>ONE OCME</b>					
29c. License number <b>OCME</b>					
29d. Date signed (Month, Day, Year) <b>SEPT 1, 2000</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>G S PRABHOO 728 BELAIR RD BALAIR MD 21014</b>					
31. Date filed (Month, Day, Year) <b>SEP 05 2000</b>					
32. Registrar's Signature 					

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene 00 27844

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Theodore John Conte</b>				2. Date of Death Month Day Year <b>August 24, 2000</b>		3. Time of Death <b>3:15 pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>309 Church Court</b>				4b. City, Town, or Location of Death <b>Westminster</b>		4c. County of Death <b>Carroll</b>	
Funeral Director	5. Social Security Number <b>212-40-0010</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>58</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Jan. 10, 1942</b>	
	9. Birthplace (State or Foreign Country) <b>MD</b>		10a. State <b>MD</b>		10b. County <b>Carroll</b>		10c. City, Town or Location <b>Westminster</b>	
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number <b>309 Church Court</b>				10f. Zip Code <b>21157</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Disabled</b>		16b. Kind of Business/Industry <b>N/A</b>			
	17. Father's Name (First, Middle, Last) <b>Pasquale Conte</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mazie Pistorio</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Maria Brennan-cousin</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12005 Manor Rd., Glen Arm, MD 21057</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Most Holy Redemmer</b>		20c. Location - City or Town, State <b>Baltimore, MD</b>		20d. Date <b>8/26/00</b>	
	21. Signature of Funeral Service Licensee  <b>William G. Dau</b>				22. Name and Address of Facility <b>Leonard J. Ruck Funeral Home, Inc. 5305 Harford Rd., Baltimore, MD 21214</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. ASCVD</b> Due to (or as a consequence of):  Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension</b>								
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier  <b>Herbert P. Henderson Jr.</b>				29c. License number <b>00051924</b>		29d. Date signed (Month, Day, Year) <b>August 25, 2006</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Herbert P. Henderson Jr. MD 295 Stoner Ave Suite 307, Westminster MD 21157</b>								
31. Date filed (Month, Day, Year) <b>SEP 05 2000</b>				32. Registrar's Signature 				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27845

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) George I. Caldwell				2. Date of Death Month Day Year August 30, 2000		3. Time of Death 11:00 PM	
	4a. Facility Name (If not institution, give street and number) Stella Maris @ Mercy Hospital				4b. City, Town, or Location of Death Baltimore City		4c. County of Death N/A	
Funeral Director	5. Social Security Number 215-09-2004		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 92 Yrs.		8. Date of Birth (Month, Day, Year) March 24, 1908	
	9. Birthplace (State or Foreign Country) Baltimore, Md.		10a. State Md.		10b. County N/A		10c. City, Town or Location Baltimore City	
Usual Residence of Decedent								
10a. State Md.			10b. County N/A			10c. City, Town or Location Baltimore City		
10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			10e. Street and Number 2921 Alvarado Square			10f. Zip Code 21234		
10g. Citizen of What Country? United States			11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 10		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Welder			16b. Kind of Business/Industry Ship Building			17. Father's Name (First, Middle, Last) George F. Caldwell		
18. Mother's Name (First, Middle, Maiden Surname) Mary F. King			19a. Informant's Name/Relationship (Type, Print) Gertrude E. Caldwell (Sister)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3609 St. Victor St. Baltimore, Maryland 21225		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Moreland Memorial Park			20c. Location - City or Town, State Baltimore, Maryland		
21. Signature of Funeral Service Licensee Milton J. Knight Jr. <i>Milton J. Knight Jr.</i>			22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214			23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Chronic Obstructive Pulmonary Disease</i> Due to (or as a consequence of): b. <i>Bilateral Lung Mass</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <i>HOSPICE</i>			27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		
28a. Date of Injury (Month, Day, Year)			28b. Time of Injury M			28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier <i>Dr. [Signature]</i>			29c. License number D40854		
29d. Date signed (Month, Day, Year) August 31, 2000			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID RISEBERG 301 ST PAUL PI BALTIMORE, MD 21202			31. Date filed (Month, Day, Year) SEP 5 2000		
32. Registrar's Signature <i>[Signature]</i>			33. State Registrar SEP 5 2000			34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020		

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

00 27846

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ETHEL C. DUNNING

2. Date of Death

Month Day Year  
AUGUST 26, 2000

3. Time of Death

9:10 PM

4a. Facility Name (If not institution, give street and number)

FUTURE CARE--CHESAPEAKE

4b. City, Town, or Location of Death

ARNOLD

4c. County of Death

ANNE ARUNDEL

Funeral  
Director

5. Social Security Number

215-03-9290

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

103 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Apr 16, 1897

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Arnold

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

305 College Parkway

10f. Zip Code

21012

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: white

To Be Completed by Funeral Director

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

unk

College (1-4 or 5+)

unk

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

teacher

16b. Kind of Business/Industry

education

17. Father's Name (First, Middle, Last)

John T. Chase

18. Mother's Name (First, Middle, Maiden Surname)

Mary E. Wright

19a. Informant's Name/Relationship (Type, Print)

Bud Dunning/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

166 Friartuck Hill Sherwood Forest, MD 21405

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street  
Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

e. Uroscopy

Due to (or as a consequence of):

b. Old Cerebrovascular Accident

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

1 Week

3 Years

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
29c. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Cyriac M.D. Attending Doctor

29c. License number

D21684

29d. Date signed (Month, Day, Year)

08-30-2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

C.V. CYRIAC M.D., 8021 RITCHIE HWY, PASADENA, MD 21122

State  
Registrar

31. Date filed (Month, Day, Year)

SEP 5 2000

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27847

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

SARAH B. EDWARDS

2. Date of Death

SEPT. 2, 2000

3. Time of Death

10:05 A.M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

JOSEPH RICHEY HOSPICE, INC.

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

217-09-7434

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

100

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

JAN. 6, 1900

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2106 RUPP STREET

10f. Zip Code

21217

10g. Citizen of What Country?

U.S. OF A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

UNKNOWN

UNKNOWN

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

DOMESTIC WORKER

16b. Kind of Business/Industry

PRIVATE FAMILIES

17. Father's Name (First, Middle, Last)

CHESTER BASS

18. Mother's Name (First, Middle, Maiden Surname)

ABBIE BASS

19a. Informant's Name/Relationship (Type, Print)

BEATRICE EDWARDS (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2106 RUPP STREET BALTIMORE, MARYLAND 21217

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CRESTLAWN MEMORIAL GARDENS

20c. Location - City or Town, State

MARIOTSVILLE, MD.

21. Signature of Funeral Service Licensee

Lewis T. Gwynn

22. Name and Address of Facility

LEWIS T. GWYNN FUNERAL HOME 21215-6393  
4517 PARK HEIGHTS AVENUE BALTO, MD

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CARDIOMYOPATHY

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 YRS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) HOSPICE

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Medical Examiner2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Lewis T. Gwynn MD

29c. License number

D0019419

29d. Date signed (Month, Day, Year)

SEPTEMBER 3, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANA H. GIBBONS, MD 900 CATO AVE BALTIMORE, MD 21229

State  
Registrar

31. Date filed (Month, Day, Year)

SEP 5 2000

32. Registrar's Signature

Dana H. Gibbons

Baltimore, Maryland 21215-0020  
pamti. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

00 27848

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Marietta Susan Edwards</b>				2. Date of Death Month Day Year <b>SEPT 1, 2000</b>		3. Time of Death <b>3:30am</b>	
	4a. Facility Name (If not institution, give street and number) <b>648 Cherry Hill Road</b>				4b. City, Town, or Location of Death <b>Street</b>		4c. County of Death <b>Harford</b>	
Funeral Director	5. Social Security Number <b>212-40-8255</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>58</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>JAN 1, 1942</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Street</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number <b>648 Cherry Hill Road</b>		10f. Zip Code <b>21154</b>	
	10g. Citizen of What Country? <b>USA</b>				11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b> College (1-4 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Mathematics Teacher</b>				16b. Kind of Business/Industry <b>Public School System</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>M. Norman Timbs</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Ellen Hughes</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>John Charles Edwards, III/Husband</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>648 Cherry Hill Rd. Street, MD 21154</b>			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory Inc.</b>		20c. Location - City or Town, State <b>Baltimore, MD</b>	
	21. Signature of Funeral Service Licensee <b>Dawn P. McDonald</b>				22. Name and Address of Facility <b>Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228</b>			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death)</b> <b>a. METASTATIC NONSMALL CELL LUNG CANCER 21 mos</b> Due to (or as a consequence of):				Approximate Interval Between Onset and Death			
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>							
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year) <b>28b. Time of Injury</b> <b>28c. Injury at Work?</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>28d. Describe how injury occurred</b>			
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <b>Michael Auerbach</b>			
To Be Completed by Physician/Medical Examiner	29c. License number <b>D33551</b>				29d. Date signed (Month, Day, Year) <b>Sept 1, 2000</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Michael Auerbach 2021 B Emmerton Rd #212 21015</b>							
To Be Completed by Physician/Medical Examiner	31. Date filed (Month, Day, Year) <b>SEP 5 2000</b>				32. Registrar's Signature <b>Benjamin A. Sparks</b>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27849

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Helen I Eyre				2. Date of Death Month Day Year Sept 2, 2000				3. Time of Death 9:45 AM	
	4a. Facility Name (If not Institution, give street and number) Cherrywood Nursing Home				4b. City, Town, or Location of Death Reisterstown				4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 160-20-5195		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		8. Date of Birth (Month, Day, Year) Aug 10, 1922		9. Birthplace (State or Foreign Country) Pennsylvania	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County Baltimore		10c. City, Town or Location Owings Mills				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 108 Allgate Road				10f. Zip Code 21117		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife			16b. Kind of Business/Industry Own Home		
	17. Father's Name (First, Middle, Last) Sebastian Coval				18. Mother's Name (First, Middle, Maiden Surname) Louise Unknown					
	19a. Informant's Name/Relationship (Type, Print) Daniel L. Eyre Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 108 Allgate Road Owings Mills, MD 21117					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Mem. Pk		20c. Date 9/6/00		20d. Location - City or Town, State Timonium, Maryland			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Eline Funeral Home 11824 Reisterstown Road Reisterstown, MD 21136					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Nonsmall Cell Carcinoma of Lung Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 2 years	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and Title of Certifier 				29c. License number D27037		29d. Date signed (Month, Day, Year) September 5 2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) I. H. Copeland MD 1838 Greene Tree Road Pikesville, MD 21208										
31. Date filed (Month, Day, Year) SEP 05 2000				32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27850

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ALAN ERDMAN</b>				2. Date of Death Month <b>AUGUST</b> Day <b>31</b> Year <b>2000</b>		3. Time of Death <b>8:51 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Northwest Hospital Center</b>				4b. City, Town, or Location of Death <b>RANDALLSTOWN</b>		4c. County of Death <b>BALTIMORE</b>		
Funeral Director	5. Social Security Number <b>213-30-5251</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>66</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>DEC. 1, 1933</b>		
	10a. State <b>MD</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>OWINGS MILLS</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>ARMY</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>OWNER</b>		16b. Kind of Business/Industry <b>LIQUOR STORE</b>			
17. Father's Name (First, Middle, Last) <b>MYER ERDMAN</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>ANNA ARENBERG</b>					
19a. Informant's Name/Relationship (Type, Print) <b>ALBA ERDMAN / WIFE</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>37 STRAWHAT ROAD #2B - OWINGS MILLS, MD 21117</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MD VETERANS CEMETERY</b>		20c. Location - City or Town, State <b>OWINGS MILLS, MD</b>		20d. Date <b>9/1/00</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Ruptured Thoracic Artery Aneurysm</b>  Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>CAD 8/P MIX 4 COPD Smoker</b>				23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				23c. Approximate Interval Between Onset and Death	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 		29c. License number <b>D44505</b>		29d. Date signed (Month, Day, Year) <b>8-31-00</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>A.J. IMPERIAL, JR MD - NWHE.</b>									
31. Date filed (Month, Day, Year) <b>SEP 5 2000</b>				32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27851

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ELAINE M. FIORE

2. Date of Death

Month Day Year  
AUGUST 30, 2000

3. Time of Death

11:05 PM

4a. Facility Name (If not institution, give street and number)

Stella Maris Hospice center

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

217-26-9461

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

68 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
JAN - 8, 1932

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4632 PARKSIDE DR.

10f. Zip Code

21206

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
8thCollege (1-4 or 5+)  
N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

TECHNITION

16b. Kind of Business/Industry

RIDE AID CORP.

17. Father's Name (First, Middle, Last)

James URBANSKI

18. Mother's Name (First, Middle, Maiden Surname)

EVELYN ITENIGER

19a. Informant's Name/Relationship (Type, Print)

Michael L. FIORE, SR.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4632 PARKSIDE DR. BALTO. MD 21206

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GARDENS OF FAITH Cem.

Date

9/2/00

20c. Location - City or Town, State

BALTO. MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

HARTLEY MILLER Funeral Home &amp; CTD.

7527 HARFORD RD. BALTO. MD 21234

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) HOSPICE

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D43725

29d. Date signed (Month, Day, Year)

9/1/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

State  
Registrar

31. Date filed (Month, Day, Year)

SEP 5 2000

32. Registrar's Signature

ORIGINAL

AUGUST 30, 2000 11:05 p.m.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-535-0059.

To Be Completed by Funeral Director

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

ELAINE FIORE



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

amend item 23a, 27, 28a, b, c, d, e, f, per me yf G787 9/26/00 **Certificate of Death**

Reg. No.

00 27852

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MATTHEW JAMES GOLDEN</b>		2. Date of Death Month Day Year <b>AUGUST 31, 2000</b>		3. Time of Death <b>01:39 AM</b>
	4a. Facility Name (If not institution, give street and number) <b>ST. JOSEPH HOSPITAL</b>		4b. City, Town, or Location of Death <b>Towson</b>		4c. County of Death <b>BALTIMORE</b>
Funeral Director	5. Social Security Number <b>215-19-2283</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>13</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>Oct 21, 1986</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State <b>Maryland</b>	10b. County <b>Baltimore County</b>	10c. City, Town or Location <b>Rodgers Forge</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <b>245 Stanmore Road</b>		10f. Zip Code <b>21212</b>		10g. Citizen of What Country? <b>USA</b>
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th</b> College (1-4 or 5+) <b>Student</b>		
	16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry <b>Middle School Education</b>		
17. Father's Name (First, Middle, Last) <b>James Joseph Golden</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Virginia Joyce Spicer</b>			
19a. Informant's Name/Relationship (Type, Print) (Parents) <b>Mrs. &amp; Mrs. James J. Golden</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>245 Stanmore Road, Baltimore, Maryland 21212</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Green Mount Crematory</b>		20c. Location - City or Town, State <b>9/4/2000 Baltimore, Maryland</b>	
21. Signature of Funeral Service Licensed <b>Martin D. Lawson (MO0358)</b>		22. Name and Address of Facility <b>Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road, Baltimore, Maryland 21212</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. HANGING</b> Dua to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. </b> Dua to (or as a consequence of):  <b>c. </b> Dua to (or as a consequence of):  <b>d. </b>		Approximate Interval Between Onset and Death			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>found: 8/31/00</b>		28b. Time of Injury <b>unknown M</b>	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>unknown</b>	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>home</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>245 Stanmore Road, Baltimore Co., MD</b>	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>[Signature]</b>		29c. License number <b>OCME</b>	
		29d. Date signed (Month, Day, Year) <b>AUGUST 31, 2000</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JASON LOCKE, MD</b>		111 Penn Street, Baltimore, Maryland 21201			
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 05 2000</b>		32. Registrar's Signature <b>[Signature]</b>		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27853  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Peter James Gangi, Jr.

2. Date of Death

SEPTEMBER 3, 2000 3:15 PM

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

216-14-0751

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

91 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

October 28, 1908

9. Birthplace (State or Foreign Country)

Lawrence, MA.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore Co.

10c. City, Town or Location

Baldwin

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13716 Baldwin Mill Road

10f. Zip Code

21013

10g. Citizen of What Country?

United States of America

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
06College (1-4 or 5+)  
n/a16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Self Employed

16b. Kind of Business/Industry

Wholesale Produce

17. Father's Name (First, Middle, Last)

Peter James Gangi, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Rosa Palmisano

19a. Informant's Name/Relationship (Type, Print) (Wife)

Mrs. Rita Antoinetta (nee Cefalu) Gangi

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13716 Baldwin Mill Road Baldwin, Maryland 21013

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

New Cathedral Cemetery

Date

9/07/2000

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Jeffrey L. Gair

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.  
1050 York Rd. Towson, Maryland 2120423a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
stroke, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

a. Due to (or as a consequence of):

MULTI ORGAN FAILURE

b. Due to (or as a consequence of):

c. PERIPHERAL VASCULAR DISEASE

d. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending  
Investigation 6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Jeffrey L. Gair

29c. License number

D41410

29d. Date signed (Month, Day, Year)

September 4th, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOGINDER P. MEHTA, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204

State  
Registrar

31. Date filed (Month, Day, Year)

SEP 05 2000

32. Registrar's Signature

B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1946 2 6 132

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27854

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Justine Toland Gagliano				2. Date of Death Month Day Year September 03, 2000		3. Time of Death 8:30 P.M.	
	4a. Facility Name (If not institution, give street and number) Gilchrist Center				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore Co.	
Funeral Director	5. Social Security Number 215-30-2149		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 68 Yrs.		8. Date of Birth (Month, Day, Year) April 04, 1932	
	9. Birthplace (State or Foreign Country) Baltimore, Maryland		10. Usual Residence of Decedent 10a. State: Maryland 10b. County: Baltimore Co. 10c. City, Town or Location: Lutherville 10d. Inside City Limits: 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		11. Merit Stelus 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Funeral Director	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 12 College (1-4 or 5+): 04		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Registered Nurse	
	16b. Kind of Business/Industry Nursing		17. Father's Name (First, Middle, Last) Andrew James Toland, Sr.		18. Mother's Name (First, Middle, Maiden Surname) Martha Mary Pietrowicz		19. Informant's Name/Relationship (Type, Print) Mrs. Kimberley M. Lang (Daughter)	
To Be Completed by Physician/Medical Examiner	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1870 Loch Shiel Road Baltimore, Maryland 21234		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify):		20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Service Corporation		20c. Location - City or Town, State Towson, Maryland	
	21. Signature of Funeral Service Licensee Jeffrey L. Gair		22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204-2515		23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Hypoxemia Due to (or as a consequence of): Metastatic lung cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death 6 wks 1 yr.	
Division of Vital Records, P.O. Box 68760,	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic obstructive pulmonary disease				23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
Medical Certification: To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
State Registrar	29b. Signature and title of certifier M. Kaminski, MD		29c. License number D31339		29d. Date signed (Month, Day, Year) 9/5/2000			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. Kaminski, MD 6701 N. Charles St. Suite 5104, Baltimore, MD 21204							
A64	31. Date filed (Month, Day, Year) SEP 05 2000		32. Registrar's Signature B. Spahr					
	DHMH 16 Rev 6/95							

ORIGINAL

Wash

000-20-130

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27855

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Maude Frances Gates				2. Date of Death Month Day Year September 2, 2000				3. Time of Death 10:10 a.m.	
	4a. Facility Name (If not institution, give street and number) Heritage Nursing Center				4b. City, Town, or Location of Death Dundalk				4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 214-12-5546		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 87 Yrs.		8. Date of Birth (Month, Day, Year) June 25, 1913		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Essex				10d. Inside City Limits 1 <input type="checkbox"/> No 2 <input checked="" type="checkbox"/> Yes		
10e. Street and Number 1000 Franklin Avenue, Apt. 919				10f. Zip Code 21221				10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) House wife				16b. Kind of Business/Industry Own Home		
17. Father's Name (First, Middle, Last) Archabald Ford				18. Mother's Name (First, Middle, Maiden Surname) Frances Ford						
19a. Informant's Name/Relationship (Type, Print) Emerson E. Gates (son)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17 TimberCreek Ct., "N", Baltimore, Md. 21221						
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) GreenMount Crematory		Date 9/4/2000		20c. Location - City or Town, State Baltimore, Maryland			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p><b>CARCINOMA OF LUNG.</b></p> <p>Due to (or as a consequence of):</p> <p><b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b></p> <p>Due to (or as a consequence of):</p> <p><b>ESSENTIAL HYPERTENSION</b></p> <p>Due to (or as a consequence of):</p> <p><b>PARKINSONS DISEASE</b></p> </div> <div style="width: 15%; text-align: center;"> <p>6 MONTHS</p> <p>10 YEARS</p> <p>15 YEARS</p> <p>5 YEARS</p> </div> </div>										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
				28d. Describe how injury occurred						
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						
				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 				29c. License number D 14160		
				29d. Date signed (Month, Day, Year) SEPTEMBER 02, 2000						
30. (Name and address of person who completed cause of death (Item 23a) (Type, Print) HARJIT SINGH M.D. 3000 HARLITCHE HIGHWAY, BALTIMORE MARYLAND - 21225.										
31. Date filed (Month, Day, Year) SEP 5 2000				32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27856

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

GRACE LILLIAN GAY

2. Date of Death

SEPTEMBER 1, 2000 6:15 AM

3. Time of Death

Funeral  
Director

4a. Facility Name (If not Institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

216-24-2457

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

6. Date of Birth

AUGUST 23, 1915

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

BALTIMORE

10c. City, Town or Location

ROSEDALE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6600 RIDGE ROAD

10f. Zip Code

21237

10g. Citizen of What Country?

UNITED STATES OF AMERICA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
6TH GRADECollege (1-4 or 5+)  
N/A16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN RESIDENCE

17. Father's Name (First, Middle, Last)

DAVID FRANK JONES

18. Mother's Name (First, Middle, Maiden Surname)

MARY SULLIVAN

19a. Informant's Name/Relationship (Type, Print)

VIVIAN NAPERT

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5654 LEIDEN ROAD / BALTIMORE, MARYLAND 21206

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

PARKWOOD CEMETERY

Date

SEP 5, 2000

20c. Location - City or Town, State

BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee

Donald R. Watson, Jr. #MO0612

22. Name and Address of Facility

6009 HARFORD ROAD  
ALTENBURG FUNERAL HOME, P.A. BALTIMORE MD 2121423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

SEPSIS

Approximate  
Interval Between  
Onset and Death

4 DAYS

Due to (or as a consequence of):

ACUTE INFERIOR MYOCARDIAL INFARCTION

4 DAYS

Due to (or as a consequence of):

ACUTE RENAL FAILURE

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Joginder P. Mehta M.D.

29c. License number

D41410

29d. Date signed (Month, Day, Year)

SEPTEMBER 15, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOGINDER P. MEHTA M.D. 7601 OSWER DRIVE TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

SEP 5 2000

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



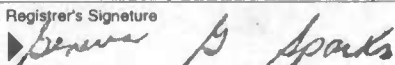
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27857

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>SEYMOUR PHILIP GOODMAN</b>				2. Date of Death Month Day Year <b>AUGUST 31, 2000</b>		3. Time of Death <b>4:00 A.M.</b>		
	4a. Facility Name (If not institution, give street and number) <b>BEDFORD COURT</b>				4b. City, Town, or Location of Death <b>SILVER SPRING</b>		4c. County of Death <b>MONTGOMERY</b>		
Funeral Director	5. Social Security Number <b>215-05-4376</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>93</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>MAY 8, 1907</b>		
	10a. State <b>MD</b>		10b. County <b>MONTGOMERY</b>		10c. City, Town or Location <b>SILVER SPRING</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>PUBLISHER</b>				16b. Kind of Business/Industry <b>NEWSPAPER</b>	
17. Father's Name (First, Middle, Last) <b>LOUIS P. GOODMAN</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>THERESA TREUMANN</b>					
19a. Informant's Name/Relationship (Type, Print) <b>ALLAN H. GOODMAN / SON</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>201 PRESCOTT COURT - GRANITE BAY, CA 95746-7137</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>HEBREW FRIENDSHIP CEMETERY</b>				20c. Location - City or Town, State <b>9/1/00 BALTIMORE, MD</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. SENILE DEMENTIA</b> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death <b>Years.</b>					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
				28d. Describe how injury occurred					
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 				29c. License number <b>D38457</b>	
				29d. Date signed (Month, Day, Year) <b>AUGUST 31, 2000</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>N. GOYAL MD, 3801 INTERNATIONAL DR #211, SILVER SPRING MD 20906</b>									
31. Date filed (Month, Day, Year) <b>SEP 5 2000</b>				32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27858

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Clarice G. Hawkins</b>				2. Date of Death Month Day Year <b>September 5, 2000</b>		3. Time of Death <b>8:15AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>14503 Green Road</b>				4b. City, Town, or Location of Death <b>Baldwin</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>175-34-4702</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>57</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>JAN 1, 1943</b>	
	9. Birthplace (State or Foreign Country) <b>North Carolina</b>		10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Baldwin</b>	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>14503 Green Road</b>		10f. Zip Code <b>21013</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>Supervisor</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Supervisor</b>		16b. Kind of Business/Industry <b>Restaurant</b>			
	17. Father's Name (First, Middle, Last) <b>John Bottom</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Leona UNK.</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Roger Hawkins/Husband</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>14503 Green Road Baldwin, MD 21013</b>			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory Inc.</b>		20c. Location - City or Town, State <b>9-5-00 Baltimore, MD</b>			
	21. Signature of Funeral Service Licensee <b>Thomas Gregor</b>		22. Name and Address of Facility <b>Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. METASTATIC LUNG CANCER</b> Dua to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Dua to (or as a consequence of):</b> <b>c. Dua to (or as a consequence of):</b> <b>d. Dua to (or as a consequence of):</b>							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how Injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <b>Robert A. Wiedersheim MD</b>				29c. License number <b>D33011</b>		29d. Date signed (Month, Day, Year) <b>9-5-00</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ROBERT A WIEDERSHEIM MD 3346 PAPER MILL Rd PHOENIX MD 21113</b>								
31. Date filed (Month, Day, Year) <b>SEP 5 2000</b>				32. Registrar's Signature <b>Benjamin A Sparks</b>				

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27859

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MAGGIE HOOD</b>				2. Date of Death Month Day Year <b>AUGUST 29, 00</b>				3. Time of Death <b>10.00</b>															
	4a. Facility Name (If not institution, give street and number) <b>ST. AGNES HEALTH CARE</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>				4c. County of Death															
Funeral Director	5. Social Security Number <b>239-34-9786</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>83</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) <b>05-01-1917</b>	9. Birthplace (State or Foreign Country) <b>S.C.</b>												
	Usual Residence of Decedent																							
10a. State <b>MD</b>		10b. County		10c. City, Town or Location <b>BALTIMORE</b>						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No														
10e. Street and Number <b>852 FRANKLINTOWN RD.</b>						10f. Zip Code <b>21216</b>			10g. Citizen of What Country? <b>U.S.A.</b>															
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>															
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+) <b>DAY CARE PROVIDED</b>						16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SELF-EMPLOYED</b>			16b. Kind of Business/Industry															
17. Father's Name (First, Middle, Last) <b>QUITMA STEWARD</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>MARY HOOD</b>																		
19a. Informant's Name/Relationship (Type, Print) <b>DEVOARK TUCKER, NEICE</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1407 NORTHGATE RD, BALTO. MD 21218</b>																		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MEADOWRIDGE PARK</b>				Date <b>09-01-00</b>		20c. Location - City or Town, State <b>ELKRIDGE MD</b>														
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility <b>HOWELL FUNERAL HOME</b> <b>4600 LIBERTY HGHTS AVE, BALTO. MD 21207</b>																		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																								
<table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a. <b>SEPSIS</b></td> <td>Due to (or as a consequence of):</td> <td>Approximate Interval Between Onset and Death <b>10 DAYS</b></td> </tr> <tr> <td>b. <b>URINERY TRACT INFECTION</b></td> <td>Due to (or as a consequence of):</td> <td><b>10 DAYS</b></td> </tr> <tr> <td>c.</td> <td>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.</td> <td>Due to (or as a consequence of):</td> <td></td> </tr> </table>												Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. <b>SEPSIS</b>	Due to (or as a consequence of):	Approximate Interval Between Onset and Death <b>10 DAYS</b>	b. <b>URINERY TRACT INFECTION</b>	Due to (or as a consequence of):	<b>10 DAYS</b>	c.	Due to (or as a consequence of):		d.	Due to (or as a consequence of):	
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. <b>SEPSIS</b>	Due to (or as a consequence of):	Approximate Interval Between Onset and Death <b>10 DAYS</b>																					
	b. <b>URINERY TRACT INFECTION</b>	Due to (or as a consequence of):	<b>10 DAYS</b>																					
	c.	Due to (or as a consequence of):																						
	d.	Due to (or as a consequence of):																						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>RECENT MYOCARDIAL INFARCTION</b> <b>EMBOLI TO RIGHT FOOT AND HAND</b> <b>CONGESTIVE HEART FAILURE</b>										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown														
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No														
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred														
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)																				
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																								
29b. Signature and title of certifier  <b>GEORGE HOKE MD, ATTENDING</b>						29c. License number <b>D53249</b>			29d. Date signed (Month, Day, Year) <b>AUGUST 29, 2000</b>															
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>GEORGE HOKE, ST. AGNES HOSPITAL</b>																								
31. Date filed (Month, Day, Year) <b>SEP 5 2000</b>				32. Registrar's Signature 																				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27860

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

FRED HAWKINS

2. Date of Death

September 5, 2000

3. Time of Death

9:45AM

4a. Facility Name (If not institution, give street and number)

Haven Nursing Home

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

NIA

Funeral  
Director

5. Social Security Number

219-54-3156

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs., last birthday)

106 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Jan. 20, 1884

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD

10b. County

NIA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3939 Penhurst Ave.

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

6th

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Steel

17. Father's Name (First, Middle, Last)

Richard Hawkins

18. Mother's Name (First, Middle, Maiden Summa)

Jeannie Hawkins

19a. Informant's Name/Relationship (Type, Print)

Vinnie Baxter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3939 Pehhurst Ave. Balto, MD. 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Mt. Zion Cemetery


Date

9-7-00

20c. Location: City or Town, State

Lansdowne, MD.

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Gary E. March Funeral Home PA.  
5400 Frederick Pass Balto, MD 2122923a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. CARDIAC ARRHYTHMIAS

Due to (or as a consequence of):

b. Atherosclerotic heart disease

Due to (or as a consequence of):

c. Congestive heart failure

Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

10 minutes

20 yrs

1 year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic atrial Fibrillation

Parkinson disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier



29c. License number

D30494

29d. Date signed (Month, Day, Year)

9-5-2000

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

W. S. K. DESA MD 4600 Wilkins Ave Baltimore MD 21229

State  
Registrar

31. Date filed (Month, Day, Year)

SEP 5 2000

32. Registrar's Signature



ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27861

amend item 23a, 27 per me G788 10/5/00 yf  
amend item 20b per fn G789 11/6/00 yf

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician /Medical Examiner  
Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>ROBERTA SUE HOOD</b>				2. Date of Death Month Day Year <b>SEPTEMBER 2, 2000</b>				3. Time of Death <b>16:35 PM</b>	
4a. Facility Name (If not institution, give street and number) <b>1206 FUSELAGE AVE.</b>				4b. City, Town, or Location of Death <b>ESSEX</b>				4c. County of Death <b>BALTIMORE</b>	
5. Social Security Number <b>212-56-5248</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>50</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>JAN. 6, 1950</b>		9. Birthplace (State or Foreign Country) <b>WEST VIRGINIA</b>	
Usual Residence of Decedent									
10a. State <b>MARYLAND</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>MIDDLE RIVER</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>1206 FUSELAGE AVENUE</b>				10f. Zip Code <b>21220</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>PHARMACIST TECHNICIAN</b>			16b. Kind of Business/Industry <b>RITE AID</b>		
17. Father's Name (First, Middle, Last) <b>ROY BROWN SMITH</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>JERLEAN HARPER</b>					
19a. Informant's Name/Relationship (Type, Print) <b>RONALD J. HOOD (HUSBAND)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1206 FUSELAGE AVENUE, BALTIMORE, MARYLAND 21220</b>					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GREENMOUNT CREMATORY</b>		Data <b>9/6/2000</b>		20c. Location - City or Town, State <b>BALTIMORE, MARYLAND</b>			
21. Signature of Funeral Service Licensee				22. Name and Address of Facility <b>BRUZDZINSKI FUNERAL HOME, P.A. 1407 OLD EASTERN AVENUE, ESSEX, MARYLAND 21221</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.  Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
				24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b>							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier <b>► [Signature]</b>		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>SEPTEMBER 3, 2000</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MARY ELLEN D. KORON</b> <b>111 Penn Street, Baltimore, Maryland 21201</b>									
31. Date filed (Month, Day, Year) <b>SEP 05 2000</b>		32. Registrar's Signature <b>[Signature]</b>							





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27862

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) William Johnston				2. Date of Death Month Day Year AUGUST 31 2000				3. Time of Death 10:23AM			
	4a. Facility Name (If not institution, give street and number) GREATER BALTIMORE MEDICAL CENTER				4b. City, Town, or Location of Death TOWSON				4c. County of Death BALTIMORE			
Funeral Director	5. Social Security Number 062-32-9147		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 67 Yrs.		If Under 1 Year Months Days		8. Date of Birth (Month, Day, Year) 12/12/1932		9. Birthplace (State or Foreign Country) Michigan	
	Usual Residence of Decedent										10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10a. State NJ		10b. County Warren		10c. City, Town or Location Great Meadows								
10e. Street and Number P.O. Box 121				10f. Zip Code 07838				10g. Citizen of What Country? USA				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: white			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Contractor				16b. Kind of Business/Industry Construction				
17. Father's Name (First, Middle, Last) William Johnston						18. Mother's Name (First, Middle, Maiden Surname) Harriet Byres						
19a. Informant's Name/Relationship (Type, Print) Davina MacKay/ sister						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 142 University Dr.; Durham, NC 27707						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Woodlawn Cemetery		Date 09/05/06		20c. Location - City or Town, State Detroit, MI				
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home Towson, MD 21204								
23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Lung Carcinoma										Approximate Interval Between Onset and Death one year		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.												
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
29b. Signature and title of certifier 				29c. License number D17873				29d. Date signed (Month, Day, Year) August 31, 2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marshall A. Levine 6569 North Charles St. Suite 205 Towson, MD												
State Registrar		31. Date filed (Month, Day, Year) SEP 05 2000				32. Registrar's Signature 						

ORIGINAL

44

SEP 08 500

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State of Maryland / Department of Health and Mental Hygiene 00 27863

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Rosa Mae Llewelyn				2. Date of Death Month Day Year Sept 2 2000				3. Time of Death 4:30 AM			
	4a. Facility Name (If not institution, give street and number) St. Agnes Hospital				4b. City, Town, or Location of Death Baltimore				4c. County of Death n/a			
Funeral Director	5. Social Security Number 240-12-0212		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 81 Yrs.		If Under 1 Year Months Days		8. Date of Birth (Month, Day, Year) Sept. 7, 1918		9. Birthplace (State or Foreign Country) North Carolina	
	Usual Residence of Decedent				10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Catonsville		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 711 Academy Road				10f. Zip Code 21228-1898				10g. Citizen of What Country? United States				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) housewife				16b. Kind of Business/Industry home				
17. Father's Name (First, Middle, Last) unknown				18. Mother's Name (First, Middle, Maiden Surname) unknown								
19a. Informant's Name/Relationship (Type, Print) Norris E. Cox - guardian				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 435 Rosecroft Terrace, Baltimore, Maryland 21229								
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park Cemetery				Date 9/5/2000		20c. Location - City or Town, State Baltimore, Maryland		
21. Signature of Funeral Service Licensee Ann Y. Zink				22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Maryland 21229								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pulmonary Edema Due to (or as a consequence of) Congestive Heart Failure Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Diabetes Mellitus, Dementia										Approximate Interval Between Onset and Death 1 Day 8 months		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus, Dementia										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				28. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 8 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Quanta Haulake, MD				29c. License number D46704		29d. Date signed (Month, Day, Year) Sept 2, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MUTOMBO KANKONDE, ST AGNES HOSPITAL BLT MD												
31. Date filed (Month, Day, Year) SEP 5 2000				32. Registrar's Signature Benita Sparks								



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State of Maryland / Department of Health and Mental Hygiene 00 27864

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Stanley Lutz</u>				2. Date of Death Month <u>09</u> Day <u>02</u> Year <u>00</u>		3. Time of Death <u>2344</u>		
	4a. Facility Name (If not institution, give street and number) <u>Levindale Hebrew Geriatric Center and Hospital</u>				4b. City, Town, or Location of Death <u>Baltimore</u>		4c. County of Death <u>N/A</u>		
Funeral Director	5. Social Security Number <u>213-01-9142</u>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <u>87</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>Aug. 10, 1913</u>		
	9. Birthplace (State or Foreign Country) <u>Maryland</u>		10a. State <u>Maryland</u>		10b. County <u>Baltimore</u>		10c. City, Town or Location <u>Baltimore</u>		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <u>2601 Putty Hill Ave. Apt. F</u>		10f. Zip Code <u>21234</u>		10g. Citizen of What Country? <u>U.S.A.</u>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>White</u>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12 years</u>		College (1-4 or 5+) <u></u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Sales Representative</u>		16b. Kind of Business/Industry <u>Food</u>			
17. Father's Name (First, Middle, Last) <u>Charles Phoenas Lutz</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Bertha Flickinger</u>					
19a. Informant's Name/Relationship (Type, Print) <u>Mary George Nooney (daughter)</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>2601 Putty Hill Ave. Apt F Baltimore, Maryland 21234</u>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Woodlawn Cemetery</u>		Date <u>9-6-00</u>		20c. Location - City or Town, State <u>Woodlawn, Maryland</u>			
21. Signature of Funeral Service Licensee <u>George J. Fennan</u>				22. Name and Address of Facility <u>Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212</u>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death	
Immediate Cause (Final disease or condition resulting in death) e. <u>CORONARY ARTERY DISEASE</u> Due to (or as a consequence of):								<u>1 YEAR</u>	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. <u>COPD</u> Due to (or as a consequence of):								<u>10 YEARS</u>	
c. <u></u> Due to (or as a consequence of):									
d. <u></u> Due to (or as a consequence of):									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <u>Kenna M. Eueley M.D.</u>		29c. License number <u>D54739</u>		29d. Date signed (Month, Day, Year) <u>September 3<sup>rd</sup> 2000</u>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>2434 W. Belvedere Avenue, Baltimore Maryland 21215</u>		31. Date filed (Month, Day, Year) <u>SEP 5 2000</u>		32. Registrar's Signature <u>Benjamin B. Sparks</u>					





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27865

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LEONARD MEREDITH

2. Date of Death

Month

Day

Year

AUGUST

31

2000

3. Time of Death

22:50

4a. Facility Name (If not institution, give street and number)

ST. AGNES HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

216-01-4303

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

93 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Dec. 10, 1906

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Arbutus

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

993 Circle Drive

10f. Zip Code

21227

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

accountant

16b. Kind of Business/Industry

distillery

17. Father's Name (First, Middle, Last)

George Meredith

18. Mother's Name (First, Middle, Maiden Surname)

Lottie May Forrester

19a. Informant's Name/Relationship (Type, Print)

Trisha Bettien - cousin

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2350 Valley Road, Schellsburg, Pennsylvania 15559

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bayview Crematory, Inc.

Date

9/02/00

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

▶ *Ann J. Zink*

22. Name and Address of Facility

Hubbard Funeral Home, Inc.

4107 Wilkens Avenue

Baltimore, Maryland

21229

23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SEPTIC SHOCK

Due to (or as a consequence of):

4 DAYS

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. LOWER GI BLEEDING

Due to (or as a consequence of):

5 DAYS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PULMONARY NODULES RIGHT LUNG

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural  
2 ☐ Accident  
3 ☐ Suicide  
4 ☐ Homicide5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

▶ *M.P.H. no* MEDICAL RESIDENT

29c. License number

P12593

29d. Date signed (Month, Day, Year)

AUGUST 31, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MOHAMMAD Y. KHAN, M.D. 900 CITON AVENUE, BALTIMORE, MARYLAND 21229

31. Date filed (Month, Day, Year)

SEP 5 2000

32. Registrar's Signature

▶ *Beverly B. Sparks*State  
Registrar

Baltimore, Maryland 21215-0020

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

NAME  
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

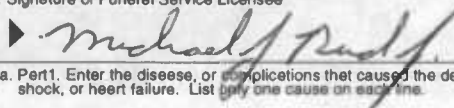
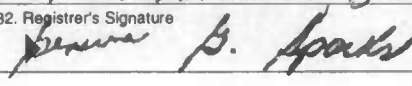
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

100

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27866  
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ALECIA ANN MULLEN</b>		2. Date of Death Month <b>Sept.</b> Day <b>1,</b> Year <b>2000</b>		3. Time of Death <b>9:30 PM</b>
	4a. Facility Name (If not institution, give street and number) <b>362 Ringhold Valley Circle</b>		4b. City, Town, or Location of Death <b>Cockeysville</b>		4c. County of Death <b>Baltimore</b>
Funeral Director	5. Social Security Number <b>217-46-1406</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>45</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>Oct. 14, 1955</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
Usual Residence of Decedent					
10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Cockeysville</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <b>362 Ringhold Valley Circle</b>			10f. Zip Code <b>21030</b>		10g. Citizen of What Country? <b>United States</b>
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>white</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>4+</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>
17. Father's Name (First, Middle, Last) <b>Milton NMN Sappe</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Elizabeth Cassidy</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Mark Mullen / husband</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>362 Ringhold Valley Circle Timonium, MD 21030</b>		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Hilltop Svc. Corporation</b>		20c. Location - City or Town, State <b>Towson, Maryland</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>OVARIAN Cancer</b>					Approximate Interval Between Onset and Death <b>7 years</b>
Due to (or as a consequence of):					
Due to (or as a consequence of):					
Due to (or as a consequence of):					
Due to (or as a consequence of):					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number <b>D30529</b>		29d. Date signed (Month, Day, Year) <b>9/5/2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>PAUL CELANO, MD 6565 N. Charles ST BALTO MD 21204</b>					
31. Date filed (Month, Day, Year) <b>SEP 05 2000</b>		32. Registrar's Signature 			

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #23 PART I, 27, 28A-F

PER. MEO G-787 9-11-00 WR.

Reg. No.

00 27867

Certificate of Death

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Roberta Moore</b>		2. Date of Death Month Day Year <b>SEPTEMBER 02 2000</b>		3. Time of Death <b>9:16 A</b>
	4a. Facility Name (If not institution, give street and number) <b>1906 MOSHER ST.</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>
Funeral Director	5. Social Security Number <b>238-15-9424</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>38</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>June 5, 1962</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State <b>Maryland</b>	10b. County <b>N/A</b>	10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <b>1906 Mosher St.</b>		10f. Zip Code <b>21217</b>		10g. Citizen of What Country? <b>USA</b>
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>0</b>		
	16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Domestic</b>		16b. Kind of Business/Industry <b>Private Family</b>		
	17. Father's Name (First, Middle, Last) <b>Robert M. Moore</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Romenia Jordan</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Mr. Bobby Moore (Brother)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4625 Marble Hall Rd. Balto. Md. 21239</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Voshell Mem. Gardens</b>		20c. Location - City or Town, State <b>Dundalk, Md.</b>
	21. Signature of Funeral Service Licensee <b>Joseph L. Russ</b>		22. Name and Address of Facility <b>Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216</b>		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>NARCOTIC, COCAINE AND ALCOHOL INTOXICATION</b>				Approximate Interval Between Onset and Death
	Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.				
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b>				
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>9-2-00</b>		
	28b. Time of Injury <b>9:06 A</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>found in house</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>1906 Mosher St. BALTO. CITY, MD</b>		
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
	29b. Signature and title of Certifier <b>Joseph L. Russ M.D.</b>		29c. License number <b>O.C.M.E</b>		29d. Date signed (Month, Day, Year) <b>SEPTEMBER 03, 2000</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Joseph L. Russ 111 Penn Street, Baltimore, Maryland 21201</b>					
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 05 2000</b>		32. Registrar's Signature <b>B. Sparks</b>		

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27868

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOSEPH ANDREW MUSCALLI				2. Date of Death Month Day Year August 29, 2000		3. Time of Death 7:35 A.M.	
	4a. Facility Name (If not institution, give street and number) 20 North Potomac Street				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 212-46-3963	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 54 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) November 27, 1945		9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number 20 North Potomac Street				10f. Zip Code 21213		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Italian	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Heavy Equipment Operator II			16b. Kind of Business/Industry Machinery	
17. Father's Name (First, Middle, Last) Michael Muscalli				18. Mother's Name (First, Middle, Maiden Surname) Lena Muscalli				
19a. Informant's Name/Relationship (Type, Print) Antonia Muscalli/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3240 Sequoia Avenue Baltimore, Md 21215				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Holy Redemer Cemetery		20c. Location - City or Town, State Baltimore, Md		
21. Signature of Funeral Service Licensee <i>William C. Brown</i>				22. Name and Address of Facility William C. Brown Community Funeral Home P.A. 1206 W. North Avenue				
23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  a. <i>Hypertensive and atherosclerotic</i> Due to (or as a consequence of): b. <i>Cardiovascular Disease</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) at scene						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and Title of certifier <i>Joseph Pestaner M.D.</i>				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) August 30, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Joseph Pestaner</i> 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) SEP 05 2000				32. Registrar's Signature <i>B. Spence</i>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27869

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ALFRED

2. Date of Death

MAJEWSKI  
AUGUST 30 2000

3. Time of Death

3:37 PM

4a. Facility Name (If not Institution, give street and number)

JOHNS HOPKINS BAYVIEW MEDICAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

207-03-7576

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

79

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug. 4, 1921

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1733 Burnham Road

10f. Zip Code

21222

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: WW II13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8 years

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Steamship Trade Mechanic

16b. Kind of Business/Industry

Steamship Trade

17. Father's Name (First, Middle, Last)

James Majewski

18. Mother's Name (First, Middle, Maiden Surname)

Frances Smulski

19a. Informant's Name/Relationship (Type, Print)

Linda Lanham (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1622 Gray Haven Court Dundalk, Maryland 21222

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☒ Other (Specify) Entombment20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Sacred Heart of Jesus

Date

9/2/00

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.

7922 Wise Avenue Dundalk, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. STAGE IIB NON SMALL CELL LUNG CANCER

Due to (or as a consequence of):

b. RADIATION PNEUMONITIS AFTER XRT

Due to (or as a consequence of):

c. ARDS

Due to (or as a consequence of):

d. COPD

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No26. Place of Death (Check only one)  
Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Amy Freedman, M.D.

29c. License number

21004

29d. Date signed (Month, Day, Year)

AUGUST 30, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AMY FREEDMAN JOHNS HOPKINS BAYVIEW MEDICAL CENTER 4440 EASTERN AVE, BALTIMORE, MD

31. Date filed (Month, Day, Year)

SEP 5 2000

32. Registrar's Signature

State  
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a show  
any injury or other traumatic event, the Medical Examiner must be notified in  
2003.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27870

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Lee Morris

2. Date of Death

Month

Day

Year

August 30, 2000

3. Time of Death

9:50 A.M.

Funeral  
Director

4e. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

216-28-0357

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Dec. 1, 1912

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

103 Center Place, Apt. 320

10f. Zip Code

21222

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12 years

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

William C. Morris

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Collier

19a. Informant's Name/Relationship (Type, Print)

Geneva Faist (Sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4 Midship Road Dundalk, Maryland 21222

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Oak Lawn Cemetery

Date

9/2/00

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Stephanie Massey

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.

7922 Wise Avenue Dundalk, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 month

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Coronary Artery Disease

Due to (or as a consequence of):

5 years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dr. Zayd Eldadah

29c. License number

D0054303

29d. Date signed (Month, Day, Year)

August 30, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Zayd Eldadah 9000 Franklin Square Drive Baltimore, MD. 21237

31. Date filed (Month, Day, Year)

SEP 5 2000

32. Registrar's Signature

[Signature]

State  
Registrar

ORIGINAL

Mary Morris  
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





jhm  
Gus  
MUTTER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
AMEND ITEMS: #23 PART 1, 11, 28A-E PER MEO G788 10 6-00 WR.  
Certificate of Death  
Reg. No. 00 21871Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

GUSTAV MUTTER

2. Date of Death  
Month Day Year  
AUGUST 29, 20003. Time of Death  
17:00 PM

4a. Facility Name (If not institution, give street and number)

ATLANTIC GENERAL HOSPITAL

4b. City, Town, or Location of Death

BERLIN

4c. County of Death

WORCESTER

Funeral  
Director

5. Social Security Number

139-36-0885

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

56

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
Sept. 23, 43

9. Birthplace (State or Foreign Country)

N.J.

Usual Residence of Decedent

10a. State

N.J.

10b. County

Morris

10c. City, Town or Location

Florham Park

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

23 Orchard Road

10f. Zip Code

07932

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Computer Programmer

16b. Kind of Business/Industry

Computer's

17. Father's Name (First, Middle, Last)

Gustav Mutter Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Mary McKenna

19a. Informant's Name/Relationship (Type, Print)

Nancy Mutter (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

23 Orchard Road Florham Park N. J. 07932

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

Sept 2, 2000

20c. Location - City or Town, State

East Hanover N.J.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DELLA NOLE & SONS FUNERAL HOME  
322 S. HIGH ST - BALTO. MD. 21202

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. DROWNING

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☒ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

8-29-00

28b. Time of Injury

4:02

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

SUBJECT DROWNED

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

IN WATER (OCEAN)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 54 TH STREET SURFLINE, OCEAN CITY, WORCESTER COUNTY, MD

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

OCME

29d. Date signed (Month, Day, Year)

AUGUST 30, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stephen S. Radentz

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

SEP 05 2000

32. Registrar's Signature

B. Sparks

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27872

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>William King Nash, Sr.</b>				2. Date of Death Month <b>Sept.</b> Day <b>01,</b> Year <b>2000</b>		3. Time of Death <b>12:44 PM</b>	
4a. Facility Name (If not institution, give street and number) <b>201 Bengies Road</b>				4b. City, Town, or Location of Death <b>Middle River</b>		4c. County of Death <b>Baltimore</b>	
5. Social Security Number <b>217-18-6406</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>76</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>JUNE 25, 1924</b>	
9. Birthplace (State or Foreign Country) <b>Virginia</b>		10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Middle River</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>201 Bengies Road</b>		10f. Zip Code <b>21220</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5</b>		15a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Pipe Fitter</b>		15b. Kind of Business/Industry <b>Canning Distributor</b>		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Pipe Fitter</b>	
17. Father's Name (First, Middle, Last) <b>David B. Nash</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Annie M. Auston</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Catherine A. Blaszkak/daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4116 Southern Avenue Baltimore, MD 21206</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory, Inc.</b>		20c. Date <b>9/5/00</b>		20d. Location - City or Town, State <b>Baltimore, MD</b>	
21. Signature of Funeral Service Licensee <b>Dawn F. McDonald</b>		22. Name and Address of Facility <b>Cremation Society of Maryland, Inc.</b>		22a. Address <b>299 Frederick Road Baltimore, MD 21228</b>		22b. City or Town, State <b>Baltimore, MD</b>	

To Be Completed by Funeral Director

Physician  
/Medical  
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>CEREBROVASCULAR DISEASE</b> Due to (or as a consequence of):  <b>DIABETES MELLITUS</b> Due to (or as a consequence of):		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown	
23c. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>CEREBROVASCULAR DISEASE</b> Due to (or as a consequence of):  <b>DIABETES MELLITUS</b> Due to (or as a consequence of):		23d. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>CEREBROVASCULAR DISEASE</b> Due to (or as a consequence of):  <b>DIABETES MELLITUS</b> Due to (or as a consequence of):	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>9/5/00</b>	
28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)		28g. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>[Signature]</b>	
29c. License number <b>D53534</b>		29d. Date signed (Month, Day, Year) <b>SEPTEMBER 1, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ROBERT CONNORS 1792 HERRITT BLVD BALTIMORE, MD 21222</b>			
31. Date filed (Month, Day, Year) <b>SEP 5 2000</b>		32. Registrar's Signature <b>[Signature]</b>	

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27873

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOSEPHINE J. OCKIMEY

2. Date of Death

September 1, 2000

3. Time of Death

1102

4a. Facility Name (If not institution, give street and number)

Sinai Hosp. Tal

4b. City, Town, or Location of Death

BALTO

4c. County of Death

Funeral  
Director

5. Social Security Number

29-14-4885

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

6-3-12

9. Birthplace (State or Foreign Country)

BALTO.

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inst'da City Limits

☒ Yes ☐ No

10e. Street and Number

1545 CLIFTON AVE

10f. Zip Code

21217

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

DOMESTIC

16b. Kind of Business/Industry

SELF-EMPLOYED

17. Father's Name (First, Middle, Last)

ROBERT BROWN

18. Mother's Name (First, Middle, Maiden Surname)

JOSEPHINE DOLEMAN

19a. Informant's Name/Relationship (Type, Print)

HAROLD OCKIMEY, GRANDSON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2421 W. GARRISON AVE, BALTIMORE, MD 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GARRISON FOREST

Date

9-7-00

20c. Location - City or Town, State

OWINGS MILLS, MD

21. Signature of Funeral Service Licensee

M. E. Howell

22. Name and Address of Facility

HOWELL FUNERAL HOME  
4600 LIBERTY HGHTS AVE, BALTO. MD 21207

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Bladder Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Metastasis to Liver

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Tobacco Use, Cystectomy

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

M. J. Kashi

29c. License number

P14271

29d. Date signed (Month, Day, Year)

September 1, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARYAM KASHI 2401 West Belvedere BALTIMORE, MD 21215

31. Date filed (Month, Day, Year)

SEP 5 2000

32. Registrar's Signature

B. Sparks

State  
RegistrarJosephine Ockimey  
Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27874

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last)

Willie Edward Phillips

2. Date of Death  
Month Day Year  
September 3 2000

3. Time of Death  
10:42 PM

4a. Facility Name (If not institution, give street and number)

Joseph Richey Hospice

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

427-30-1380

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

JULY 26, 1923

9. Birthplace (State or Foreign Country)

Tennessee

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

University Park

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6404 Queens Chapel Road

10f. Zip Code

20782

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: W.W.II

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Research Physicist/Professor

16b. Kind of Business/Industry

College/  
Federal Government

17. Father's Name (First, Middle, Last)

Cicero Buchanan Phillips

18. Mother's Name (First, Middle, Maiden Surname)

Willie Padilla Hendrix

19a. Informant's Name/Relationship (Type, Print)

Maxie Doddson Phillips /Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6404 Queens Chapel Rd. University Park, MD 20782

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory Inc.

Date

9-5-00

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Edward A. Gregorchik

22. Name and Address of Facility

Cremation Society of MD, Inc.  
299 Frederick Road Baltimore, MD 21228

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Carcinoma Colon  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 yrs.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Robert C. Irwin MD

29c. License number

D08910

29d. Date signed (Month, Day, Year)

9-5-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert C. Irwin MD 828 N. Eutaw St Baltimore, MD 21201

31. Date filed (Month, Day, Year)

SEP 5 2000

32. Registrar's Signature

Benjamin Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Willie Phillips 9/3/00 1042pm

10  
w.j.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27875

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Annie Patterson</b>		2. Date of Death Month <b>Aug.</b> Day <b>27</b> Year <b>2000</b>		3. Time of Death <b>12:00n</b>
	4a. Facility Name (If not institution, give street and number) <b>Canton Harbor Nursing Home</b>		4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>NA</b>
Funeral Director	5. Social Security Number <b>213-20-0500</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>75</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>05-17-24</b>		9. Birthplace (State or Foreign Country) <b>VA</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State <b>FL.</b>	10b. County <b>NA</b>	10c. City, Town or Location <b>Tampa</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <b>7905 Landmark Lane</b>		10f. Zip Code <b>33615</b>		10g. Citizen of What Country? <b>USA</b>
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th Grade</b> College (1-4 or 5+) <b>NA</b>		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Domestic</b>		16b. Kind of Business/Industry <b>various trades</b>		
	17. Father's Name (First, Middle, Last) <b>James Jones</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Sarah Jones</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Norman H. Patterson, Jr.</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7905 Landmark Lane Tampa Florida 33615</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Parkwood Cemetery</b>		20c. Location - City or Town, State <b>08-31-2000 Baltimore Co., MD</b>
	21. Signature of Funeral Service Licensee <b>Gladys W...</b>		22. Name and Address of Facility <b>Baltimore, Maryland 21202</b> <b>WM.C.March FH 1101 E. North Avenue</b>		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death
	a. <b>Cancer of the uterine Cervix with metas-</b> Due to (or as a consequence of):				
	b. <b>tasis to Urinary bladder + Colon</b> Due to (or as a consequence of):				
	c. Due to (or as a consequence of):				
	d. Due to (or as a consequence of):				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Renal failure</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day Year)		28b. Time of injury <b>M</b>
	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>Melito M. Torres</b>		29c. License number <b>MD11150</b>		29d. Date signed (Month, Day, Year) <b>8/29/2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MELITO M. TORRES MD 441 S. ELLWOOD AVE. BALTO, MD 21224</b>					
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 5 2000</b>		32. Registrar's Signature <b>[Signature]</b>		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27876

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

SARA ELEANOR POLLOCK

2. Date of Death  
Month Day Year  
SEPTEMBER 3, 20003. Time of Death  
9:45 a.m.

4a. Facility Name (If not institution, give street and number)

1621 RICKENBACKER ROAD, APARTMENT "B"

4b. City, Town, or Location of Death

ESSEX

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

215-16-2397

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

NOV. 5, 1912

9. Birthplace (State or Foreign Country)

PENNSYLVANIA

Usual Residence of Decedent

10a. State  
MARYLAND10b. County  
BALTIMORE

10c. City, Town or Location

ESSEX

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

1621 RICKENBACKER ROAD, APARTMENT "B"

10f. Zip Code

21221

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

HOUSEWIFE

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

WILLIAM RICE

18. Mother's Name (First, Middle, Maiden Surname)

UNK

19a. Informant's Name/Relationship (Type, Print)

JOAN STUNZ (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1621 RICKENBACKER ROAD, BALTIMORE, MARYLAND 21221

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation ☒ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Oxford cemetery

Date

9/7/2000

20c. Location - City or Town, State

Oxford, Pennsylvania

21. Signature of Funeral Services Licensee

22. Name and Address of Facility

BRUZZINSKI FUNERAL HOME, P.A.

1407 OLD EASTERN AVENUE, ESSEX, MARYLAND 21221

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, organ failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)a. *arterio-sclerotic cardiovascular disease*

Due to (or as a consequence of)

b. *Diabetes mell. Ins*

Due to (or as a consequence of)

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be  
3 ☐ Suicide 4 ☐ Homicide determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D00010032

29d. Date signed (Month, Day, Year)

9/5/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LOUIS SEMENOFF 2108 OREMS RD BALTIMORE 21220

31. Date filed (Month, Day, Year)

SEP 5 2000

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27877

Amended Item#22 perABG787 9/5/2000 EW

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ERMA MARIE PAUL				2. Date of Death Month Day Year AUGUST 29 2000				3. Time of Death 2:05 PM			
	4a. Facility Name (If not institution, give street and number) Sacred Heart Hospital				4b. City, Town, or Location of Death Cumberland				4c. County of Death Allegany			
Funeral Director	5. Social Security Number 215-20-7347		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 93 Yrs.		8. Date of Birth (Month, Day, Year) June 6, 1907		9. Birthplace (State or Foreign Country) MD			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State MD		10b. County Allegany		10c. City, Town or Location Cumberland				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number 1 Baltimore Street				10f. Zip Code 21502		10g. Citizen of What Country? USA					
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) housewife			16b. Kind of Business/Industry none				
	17. Father's Name (First, Middle, Last) John Paul				18. Mother's Name (First, Middle, Maiden Surname) Blanche /Stalling							
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) David Paul/nephew				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 508 Regina Drive Cumberland, MD 20502							
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place)		Date		20c. Location - City or Town, State			
	21. Signature of Funeral Service Licensee Ronald S. Wade, Director				22. Name and Address of Facility State Anatomy Board 655 Baltimore Street Baltimore, MD 21201							
	23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CEREBROVASCULAR ACCIDENT Due to (or as a consequence of): b. CHRONIC ATRIAL FIBRILLATION Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death 10 DAYS 5 YEARS	
	Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CONGESTIVE HEART FAILURE								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier PHYSICIAN				29c. License number D50844		29d. Date signed (Month, Day, Year) AUGUST 29, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOSE LOVERIA JR. 912 SETON DRIVE CUMBERLAND, MD 21502												
State Registrar	31. Date filed (Month, Day, Year) SEP 5 2000				32. Registrar's Signature B Sparks							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27878

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Lynn Eden Perrault</b>				2. Date of Death Month <b>Sept</b> Day <b>3</b> , Year <b>2000</b>		3. Time of Death <b>2:30 am</b>		
	4a. Facility Name (If not institution, give street and number) <b>708 Earlton Road</b>				4b. City, Town, or Location of Death <b>Reisterstown</b>		4c. County of Death <b>Baltimore</b>		
Funeral Director	5. Social Security Number <b>213-48-8580</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>50</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>May 11, 1950</b>		
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Reisterstown</b>		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>708 Earlton Road</b>		10f. Zip Code <b>21136</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (14 or 5+) <b>5 +</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Project Manager</b>		16b. Kind of Business/Industry <b>Banking</b>		17. Father's Name (First, Middle, Last) <b>Robert Lincoln Smith</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Ruth Augusta Jenkins</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Stephen V. Perrault</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>708 Earlton Road Reisterstown, Maryland 21136</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Evergreen Mem. Park</b>		20c. Location - City or Town, State <b>9/6/00 Finksburg, Maryland</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Eline Funeral Home 21136 11824 Reisterstown Road Reisterstown, Maryland</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Varicella encephalitis</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
23a. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>chronic lymphocytic leukemia</b> <b>hypertension</b>		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined	
28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Dan Rosenberg MD</b>		29c. License number <b>D40854</b>		29d. Date signed (Month, Day, Year) <b>September 5, 2000</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dan Rosenberg 301 St Paul Place Baltimore, MD 21202</b>	
31. Date filed (Month, Day, Year) <b>SEP 05 2000</b>		32. Registrar's Signature 		33. Date of Death <b>Sept 3, 2000</b>		34. Time of Death <b>2:30 am</b>		35. Race <b>White</b>	

ORIGINAL

SEP 6 9 32

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State of Maryland / Department of Health and Mental Hygiene

00 27879

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ROBERT J POWELL

2. Date of Death

Month Day Year  
AUG 31 2000

3. Time of Death

11:15 PM

4a. Facility Name (If not institution, give street and number)

5842 Stevens Forest Road #12

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

Funeral  
Director

5. Social Security Number

214-48-2456

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

56

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month, Day, Year  
May 27, 1944

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Columbia

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5842 Stevens Forest Road

10f. Zip Code

21045

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Factory Worker

16b. Kind of Business/Industry

Manufacturing

17. Father's Name (First, Middle, Last)

Thomas H. Powell

18. Mother's Name (First, Middle, Maiden Surname)

Florence Agnes Donnelly

19a. Informant's Name/Relationship (Type, Print)

Mr. Thomas H. Powell

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12905 Falls Road Cockeysville, Maryland 21030

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Lakeview Memorial Park

Date

09/05/00

20c. Location - City or Town, State

Sykesville, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Slack Funeral Home, P.A.  
3871 Old Columbia Pike Ellicott City, MD 2104323a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

years

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Bipolar Disorder

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] Deputy ME

29c. License number

D314173

29d. Date signed (Month, Day, Year)

Sept 1, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PATRYCE A. TOYE, MD 4565 Hemlock Cone Way Ellicott City MD 21042

31. Date filed (Month, Day, Year)

SEP 5 2000

32. Registrar's Signature

[Signature]

State  
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





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State of Maryland / Department of Health and Mental Hygiene 00 27880

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

PAUL K SARRIS

2. Date of Death

SEPT 1 2008

3. Time of Death

8:25 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Joseph Richey Hospice

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

204-26-0605

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
June 13, 1933

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

Bladensburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4004 48th Street

10f. Zip Code

20710

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: 1953-7313. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Safety Director

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

James Sarris

18. Mother's Name (First, Middle, Maiden Summa)

Ida Mae Wise

19a. Informant's Name/Relationship (Type, Print)

Ida Faye Sarris/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4004 48th Street Bladensburg, MD 20710

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metro Crematory, Inc. 9/5/00

Date

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Edward A. Sarris  
Edward A. Sarris

22. Name and Address of Facility

Cremation Society of MD, Inc.  
299 Frederick Road Baltimore, MD 2122823a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. METASTATIC LUNG CANCER

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

6 MONTHS

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) HOSPICE

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Paul Sarris MD

29c. License number

D18587

29d. Date signed (Month, Day, Year)

SEPT 1 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paul Gormley 900 CATON AVE BALTIMORE MD 21229

31. Date filed (Month, Day, Year)

EP 5 2000

32. Registrar's Signature

James Sarris

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
document.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 00 27881

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Lily Summerville

2. Date of Death

Month Day Year  
Sept. 01, 2000

3. Time of Death

8:25pm

4a. Facility Name (If not institution, give street and number)

3838 Reisterstown Road

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

NA

Funeral  
Director

5. Social Security Number

214-26-6164

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
09-10-15

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

3838 Reisterstown Road

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

11th Grade

NA

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

various trades

17. Father's Name (First, Middle, Last)

James Diggs

18. Mother's Name (First, Middle, Maiden Surname)

Josephine Forbes

19a. Informant's Name/Relationship (Type, Print)

William H. Johnson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4727 Winterset Way Owings Mills, Maryland 21117

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Crownsville VA Cem. 09-05-2000 Crownsville, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

▶ Gladys Wane

22. Name and Address of Facility

Baltimore, Maryland 21202  
WM.C.March FH 1101 E. North Avenue

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Failure to thrive

Due to (or as a consequence of):

b. Pulmonary embolus

Due to (or as a consequence of):

c. Myocardial Infarction

Due to (or as a consequence of):

d. Ischemic Atrial Fibrillation

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Severe Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of injury

(Month, Day Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

▶ S. Schatz

29c. License number

D50296

29d. Date signed (Month, Day, Year)

9/5/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHASTINE ADAMS 4 WEST HOLLING RD st. 100 CATONSVILLE, MD 21228

State  
Registrar

31. Date filed (Month, Day, Year)

SEP 5 2000

32. Registrar's Signature

▶ [Signature] Sparks

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27882

## Certificate of Death

Reg. No.

amend item 23a, 27 per me G788 10/5/00 yf

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Dante Smith</b>		2. Date of Death Month <b>September</b> Day <b>01</b> Year <b>2000</b>		3. Time of Death <b>7:55 A.M.</b>
	4a. Facility Name (If not institution, give street and number) <b>Sinai Hospital</b>		4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>
Funeral Director	5. Social Security Number <b>215-92-7680</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>23</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>08-19-77</b>		9. Birthplace (State or Foreign Country) <b>MD</b>		
Usual Residence of Decedent					
10a. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number <b>4407 Moravia Road Apt. #4</b>			10f. Zip Code <b>21206</b>		10g. Citizen of What Country? <b>USA</b>
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th Grade</b> College (1-4 or 5+) <b>NA</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Correctional Officer</b>		16b. Kind of Business/Industry <b>Dept. of Public Safety + Corrections</b>	
17. Father's Name (First, Middle, Last) <b>Rodney Smith</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Felicia Edwards</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Rodney Smith</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1514 N. Linwood Avenue Baltimore, MD 21213</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Woodlawn Cemetery</b>		20c. Location - City or Town, State <b>09-06-2000 Woodlawn, MD</b>	
21. Signature of Funeral Service Licensee <b>Gabriele Curb</b>		22. Name and Address of Facility <b>Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. SICKLE CELL DISEASE</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>24</b>		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>Kenneth Delfino</b>		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>September 02, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>M. K. Korman 111 Penn Street, Baltimore, Maryland 21201</b>					
31. Date filed (Month, Day, Year) <b>SEP 05 2000</b>		32. Registrar's Signature <b>[Signature]</b>			

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27883

AMEND #1 PER MD. G787 9-27-2000 JAB

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) **FRATESSA Anne Elizabeth Scoville** 2. Date of Death Month **Aug** Day **31** Year **2000** 3. Time of Death **9:03 PM**

Funeral  
Director

4a. Facility Name (If not institution, give street and number) **Gilchrist Hospice Center** 4b. City, Town, or Location of Death **Baltimore** 4c. County of Death **Baltimore City**

5. Social Security Number **551-42-9093** 6. Sex **1** ☐ M ☒ F 7. Age (In yrs. last birthday) **68** Yrs. 8. Date of Birth (Month, Day, Year) **Jan 17, 1932** 9. Birthplace (State or Foreign Country) **California**

Usual Residence of Decedent

10a. State **California** 10b. County **Monterey** 10c. City, Town or Location **Pebble Beach** 10d. Inside City Limits ☐ Yes ☒ No

10e. Street and Number **#10 Ocean Pines** 10f. Zip Code **93953** 10g. Citizen of What Country? **U.S.A.**

11. Marital Status **1** ☐ Never Married **2** ☐ Married **3** ☐ Widowed **4** ☒ Divorced 12. Was Decedent Ever in U.S. Armed Forces? **1** ☐ Yes **2** ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) **1** ☐ Yes **2** ☒ No Specify: 14. Race - American Indian, Black, White, etc. Specify: **White**

15. Decedent's Education (Specify only highest grade completed) **Elementary/Secondary (0-12)** **College (1-4or 5+)** **4** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) **Property Manager** 16b. Kind of Business/Industry **Real Estate**

17. Father's Name (First, Middle, Last) **Joseph B. Fratesa** 18. Mother's Name (First, Middle, Maiden Surname) **Catherine Flanagan**

19a. Informant's Name/Relationship (Type, Print) **Ms. Michelle A. Scoville** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **10899 Beech Creek Dr. Columbia, Maryland 21044**

20a. Method of Disposition **1** ☐ Burial **2** ☒ Cremation **3** ☐ Removal from State **4** ☐ Donation **5** ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) **All County Cremation Services, Inc.** Data **09/06/00** 20c. Location - City or Town, State **Sykesville, Maryland**

21. Signature of Funeral Service Licensee **[Signature]** 22. Name and Address of Facility **Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Lung Cancer** Approximate Interval Between Onset and Death **2 years**

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? **1** ☐ Yes **2** ☒ No **3** ☐ Probably **4** ☐ Unknown

24a. Was an autopsy performed? **1** ☐ Yes **2** ☒ No

24b. Were autopsy findings available prior to completion of cause of death? **1** ☐ Yes **2** ☐ No

25. Was case referred to medical examiner? **1** ☐ Yes **2** ☒ No 26. Place of Death (Check only one) Hospital: **1** ☐ Inpatient **2** ☐ ER/Outpatient **3** ☐ DOA Other: **4** ☐ Nursing Home **5** ☐ Residence **6** ☒ Other (Specify) **Hospice**

27. Manner of Death **1** ☒ Natural **5** ☐ Pending investigation **2** ☐ Accident **6** ☐ Could not be determined **3** ☐ Suicide **4** ☐ Homicide

28a. Date of Injury (Month, Day, Year) 28b. Time of Injury **M** 28c. Injury at Work? **1** ☐ Yes **2** ☐ No 28d. Describe how injury occurred 28e. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) **1** ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **2** ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier **[Signature]** 29c. License number **025205** 29d. Date signed (Month, Day, Year) **September 1, 2000**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) **W.A. R. Toy G. B. H. C. 6701 N. Charles St. Balt. and 21201**

State  
Registrar

31. Date filed (Month, Day, Year) **SEP 5 2000** 32. Registrar's Signature **[Signature]**

Scoville, Anne August 31, 2000 9:03pm  
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27884

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

John Satterfield

2. Date of Death

08 - 30 - 2000 7:59pm

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Lorien Frankford

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore City

Funeral  
Director

5. Social Security Number

244-42-9837

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

68

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Sept 25, 1931

9. Birthplace (State or Foreign Country)

N.C.

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

3103 Loch Raven

10f. Zip Code

21218

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☒ Navar Married ☐ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Butcher

16b. Kind of Business/Industry

Meat Company

17. Father's Name (First, Middle, Last)

Major Satterfield

18. Mother's Name (First, Middle, Maiden Sumama)

Odell Rogers

19a. Informant's Name/Relationship (Type, Print)

Tammy Satterfield/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6811 Dunbar Rd Balto., MD 21222

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Mt. Zion Cemetery Sept. 6, 2000 Baltimore, MD

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

CALVIN B. SCRUGGS FUNERAL HOME

1412 E. PRESTON STREET BALTO. MD 21213

23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)a. Metastatic Squamous Cell Carcinoma  
of Lung

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Coma

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☒ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA ☒ Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending  
Investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D30641

29d. Date signed (Month, Day, Year)

September 1st 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ramesh Sabarathi 201-109 Back River Neck Rd Balt, MD 21221

31. Date filed (Month, Day, Year)

SEP 5 2000

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

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within 24 hours after death.  
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completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Unknown 00-240

amend item 23a, 27, 28a, b, c, d, e, f per me

Rosemarie Pierorazio Shew G788 10/4/00 yf

Certificate of Death

Reg. No.

00 27885

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Rosemarie Pierorazio Shew

2. Date of Death

Month Day Year  
August 28, 2000

3. Time of Death

7:51 A.M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

West Cherry Hill Road and Franklin Boulevard

4b. City, Town, or Location of Death

Reisterstown

4c. County of Death

Baltimore

5. Social Security Number

215-48-5418

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

38

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 1, 1961

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Essex

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

7 Avenal Road

10f. Zip Code

21221

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12 YearsCollege (1-4 or 5+)  
4 Years16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Fred Pierorazio

18. Mother's Name (First, Middle, Maiden Surname)

Rose Marie Lipari

19a. Informant's Name/Relationship (Type, Print)

Mike Pierorazio (Brother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5249 Stone Bridge Way Sykesville, Maryland 21784

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☒ Other (Specify) Entombment20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Sacred Heart of Jesus

Date

9/1/00

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.  
7922 Wise Avenue Dundalk, Maryland 2122223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each lineApproximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. BLUNT AND SHARP FORCE INJURIES

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) at scene

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☒ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)  
found: 8/28/00

28b. Time of Injury

found: 7:46

28c. Injury at Work?

1 ☐ Yes 2 ☒ No28d. Describe how injury occurred subject struck  
with blunt/sharp force28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

found at construction site

28f. Location (Street and Number or Rural Route Number,  
City or Town, State) W. Cherry Hill Road  
and Franklin Boulevard Reisterstown,  
Md.29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician:2 ☒ Medical Examiner:To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

August 29, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dennis Chute M.D.

111 Penn Street, Baltimore, Maryland 21201

State  
Registrar

31. Date filed (Month, Day, Year)

SEP 05 2000

32. Registrar's Signature

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
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Important: If item 27 is marked other than "natural", or item 23a or 28a-f show  
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/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27886

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Karen Paulette Townsend

2. Date of Death

Month Day Year  
SEPTEMBER 4 2000

3. Time of Death

2:40 PM

4a. Facility Name (If not institution, give street and number)

St. Agnes Hospital 900 CATON AVENUE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

216-42-0492

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

55 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
AUG 19, 1945

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Elkridge

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

6320 Orchard Club Drive Apt#101

10f. Zip Code

21075

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Office Manager

16b. Kind of Business/Industry

Insurance

17. Father's Name (First, Middle, Last)

Ralph Ehrlich

18. Mother's Name (First, Middle, Maiden Surname)

Clara Polansky

19a. Informant's Name/Relationship (Type, Print)

Kirk Fielder/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1032 Cowpens Ave. Towson, MD 21286

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Metro Crematory Inc.

Date

9-5-00

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Thomas Gregor

22. Name and Address of Facility

Cremation Society of MD, Inc.

299 Frederick Road Baltimore, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CEREBROVASCULAR Accident

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension, Renal failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

George Durst M.D.

29c. License number

P14442

29d. Date signed (Month, Day, Year)

SEPTEMBER 4, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GEORGE DURST, M.D. 900 CATON AVENUE, BALTIMORE, MARYLAND 21228

State  
Registrar

31. Date filed (Month, Day, Year)

SEP 5 2000

32. Registrar's Signature

George Durst

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.NAME  
Karen Paulette Townsend  
Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

amend item 23a,27 per me G788 10/25/00 yf

## Certificate of Death

Reg. No.

00 27887

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Denise A. Thomas</b>				2. Date of Death Month <b>August</b> Day <b>28</b> Year <b>2000</b>		3. Time of Death <b>01:15 P.M.</b>		
	4a. Facility Name (If not institution, give street and number) <b>5229 Beaufort Avenue</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>		
Funeral Director	5. Social Security Number <b>218-62-3362</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>47</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>05-15-53</b>		
	10a. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
Usual Residence of Decedent				10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th Grade</b> College (1-4 or 5+) <b>NA</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Assembly Line</b>		16b. Kind of Business/Industry <b>Dover Poultry</b>			
17. Father's Name (First, Middle, Last) <b>Richard Thomas</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Geraldine Street</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Geraldine + Gladys Thomas</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1905 cecil Avenue Baltimore, Maryland 21218</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Voshell Mem. Gardens</b>		20c. Location - City or Town, State <b>09-02-2000 Dundalk, MD</b>		20d. Date	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Baltimore, Maryland 21202 WM.C.March FH 1101 E.North Avenue</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>MYOCARDIAL FIBROSIS AND FATTY LIVER IN</b> a. <b>ASSOCIATION WITH CHRONIC ALCOHOLISM AND DRUG USE</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
				24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
				24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Scene</b>					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
				28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>August 29, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MARY G. RIPLEY, M.D. 111 Penn Street, Baltimore, Maryland 21201</b>									
31. Date filed (Month, Day, Year) <b>SEP 05 2000</b>				32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

00 27888

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>THELMA J. TYNDALL</b>				2. Date of Death Month Day Year <b>August 22, 2000</b>				3. Time of Death <b>6:55 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>930 2nd Street</b>				4b. City, Town, or Location of Death <b>Pocomoke</b>				4c. County of Death <b>Worcester</b>		
Funeral Director	5. Social Security Number <b>218-24-4263</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>71</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Dec 24, 1928</b>		9. Birthplace (State or Foreign Country) <b>MD</b>		
	Usual Residence of Decedent										
10a. State <b>MD</b>		10b. County <b>Worcester</b>		10c. City, Town or Location <b>Pocomoke</b>				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number <b>930 2nd Street</b>				10f. Zip Code <b>21851</b>				10g. Citizen of What Country? <b>USA</b>			
11. Marital Status 1 <input type="checkbox"/> Navar Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>white</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+) <b>0</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>seamstress</b>				16b. Kind of Business/Industry <b>garment</b>			
17. Father's Name (First, Middle, Last) <b>Severn Whitehead</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Tennis L. Bowden</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Audrey Williams/sister</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2240 Bypass Road Pocomoke, MD 21851</b>							
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place)		Date		20c. Location - City or Town, State			
21. Signature of Funeral Service Licensee <b>Ronald S. Wade, Director</b>				22. Name and Address of Facility <b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death	
Immediate Cause (Final disease or condition resulting in death) e. <b>Congestive Heart Failure</b> Due to (or as a consequence of): f. <b>Renal Failure</b> Due to (or as a consequence of): g. _____ Due to (or as a consequence of): h. _____ Due to (or as a consequence of):											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes Mellitus-II; hyperlipidemia; Renal Artery Stenosis S/P Stent; S/P Thyroidectomy</b>										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <b>[Signature]</b>				29c. License number <b>D 0054422</b>		29d. Date signed (Month, Day, Year) <b>8/28/00</b>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>1604 - Market St.; Pocomoke; MD 21851</b>											
31. Date filed (Month, Day, Year) <b>SEP 5 2000</b>				32. Registrar's Signature <b>[Signature]</b>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27889

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Elroy J Thomas Sr.				2. Date of Death Month 09 Day 03 Year 00		3. Time of Death 19:08		
	4a. Facility Name (If not institution, give street and number) University of Maryland Medical System				4b. City, Town, or Location of Death Baltimore		4c. County of Death —		
Funeral Director	5. Social Security Number 215-24-3744	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 70 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 05, 21, 1930	9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Maryland	10b. County N/A	10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number 2038 Ruxton Avenue			10f. Zip Code 21216		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0 College (1-4 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver		16b. Kind of Business/Industry Oil Company				
	17. Father's Name (First, Middle, Last) Charles Thomas				18. Mother's Name (First, Middle, Maiden Surname) Evelyn Nicholson				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) (wife) Mrs. Theresa Thomas				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2038 Ruxton Ave. Balto. Md. 21216				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill		20c. Location - City or Town, State Glen Burnie, Md.		20d. Date 9/11/2000		
	21. Signature of Funeral Service Licensee Joseph L. Russ		22. Name and Address of Facility Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Congestive Heart Failure Due to (or as a consequence of): b. Ischemic Dilated Cardiomyopathy Due to (or as a consequence of): c. Hypertension Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier C Jones - Burton, M.D.		29c. License number P13383		29d. Date signed (Month, Day, Year) 09-03-00			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C Jones - Burton, M.D. 22 S. Greene street Baltimore Maryland 21201									
State Registrar	31. Date filed (Month, Day, Year) SEP 5 2000		32. Registrar's Signature [Signature]						

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27890

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARTIN OLIVER URBAN

2. Date of Death

Month Day Year  
SEPTEMBER 1, 2000

3. Time of Death

0610

4a. Facility Name (If not institution, give street and number)

Good Samaritan Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

212-03-8283

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Nov. 23, 1921

9. Birthplace (State or Foreign Country)

Baltimore, Md.

Usual Residence of Decedent

10a. State

Md.

10b. County

N/A

10c. City, Town or Location

Baltimore City

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3401 Northway Drive

10f. Zip Code

21234

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Blueprinter

16b. Kind of Business/Industry

Printing

17. Father's Name (First, Middle, Last)

Charles M. Urban

18. Mother's Name (First, Middle, Maiden Surname)

Genevieve Dugent

19a. Informant's Name/Relationship (Type, Print)

Julia I. Urban (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3401 Northway Drive Baltimore, Md. 21234

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☒ Other (Specify) Entombment

20b. Place of Disposition (Name of cemetery, crematory or other place)

Moreland Memorial Park 9/5/00

Date

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee Milton J Knight Jr

Milton J Knight Jr

22. Name and Address of Facility

Leonard J. Ruck, Inc.

5305 Harford Road Baltimore, Maryland 21214

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE RESPIRATORY FAILURE

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

&lt; 24 hrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CEREBRAL EDEMA

Due to (or as a consequence of):

48 hrs

c. ACUTE LEFT MIDDLE CEREBRAL ARTERY INFARCTION

Due to (or as a consequence of):

48 hrs

d. ATHEROSCLEROSIS LEFT INTERNAL CAROTID ARTERY

10+ yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

HYPERTENSION

TYPE II Diabetes mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

John Flogues

29c. License number

D16534

29d. Date signed (Month, Day, Year)

9/1/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHN F. ROGERS, MD 5601 LOCHRAVEN BOULEVARD

BALTIMORE MD 21239

State  
Registrar

31. Date filed (Month, Day, Year)

SEP 5 2000

32. Registrar's Signature

Genevieve A Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27891

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Matt Vavreck, Jr.</b>				2. Date of Death Month Day Year <b>August 31, 2000</b>		3. Time of Death <b>6:05 p.m.</b>		
	4a. Facility Name (If not institution, give street and number) <b>2 Center Section Court</b>				4b. City, Town, or Location of Death <b>Middle River</b>		4c. County of Death <b>Baltimore</b>		
Funeral Director	5. Social Security Number <b>208-09-0016</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>82</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>April 13, 1918</b>	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>	
	Usual Residence of Decedent								
10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Middle River</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>2 Center Section Court</b>				10f. Zip Code <b>21220</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1946-1950</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+)				18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Welder</b>			16b. Kind of Business/Industry <b>Aero-space</b>		
17. Father's Name (First, Middle, Last) <b>Matthew Vavreck, Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Pacek</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Anna M. Vavreck (wife)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2 Center Section Court, Baltimore, Maryland 21220</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Holly Hill Mem. Gardens</b>		Date <b>9/4/2000</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Bruzdziński Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. CEREBROVASCULAR ACCIDENT</b> Due to (or as a consequence of): <b>b. HYPERTENSION</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.								Approximate Interval Between Onset and Death <b>19 YEARS</b>  <b>YEARS</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 			29c. License number <b>D 06933</b>		29d. Date signed (Month, Day, Year) <b>SEPTEMBER 12 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JOHN B. MCGIBBON MD 300 ARMORY PLACE 34 BALTIMORE MD 21201</b>									
31. Date filed (Month, Day, Year) <b>SEP 5 2000</b>		32. Registrar's Signature 							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at 302-358-3000.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27892  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

HARVEY VEST

2. Date of Death

Month Day Year  
AUGUST 30, 2000

3. Time of Death

1:05 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

JOHNS HOPKINS BAYVIEW MEDICAL CENTER

4b. City, Town, or Location of Death

BALTIMORE, MD

4c. County of Death

BALTIMORE CITY

5. Social Security Number

232-42-6769

6. Sex

M 2 ☐ F

7. Age (In yrs. last birthday)

78

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Jan. 6, 1922

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Essex

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

2210 Poplar Road

10f. Zip Code

21221

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

☒ Yes ☐ No 1940-  
If Yes, Give Year or Dates: 194513. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
6

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Machinist

16b. Kind of Business/Industry

Shipyard

17. Father's Name (First, Middle, Last)

Harvey W. Vest

18. Mother's Name (First, Middle, Maiden Surname)

Martha S. Summerfield

19a. Informant's Name/Relationship (Type, Print)

Anna S. Vest (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2210 Poplar Road, Baltimore, Maryland 21221

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Holly Hill Mem. Gardens

Date

9/2/2000

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bruzdinski Funeral Home, P.A.  
1407 Old Eastern Avenue, Essex, Maryland 2122123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. MULTISYSTEM ORGAN FAILURE

12 hours

Due to (or as a consequence of):

b. ISCHEMIC BOWEL

9 days

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☒ No25. Was case referred to medical  
examiner?  
☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide28a. Date of Injury  
(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Mark J. Gonzalvo, MD

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

AUGUST 30, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mark Gonzalvo, M.D., JHMC, 4940 Eastern Avenue, Baltimore, Maryland 21224

31. Date and Time (Month, Day, Year)

SEP 5 2000

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

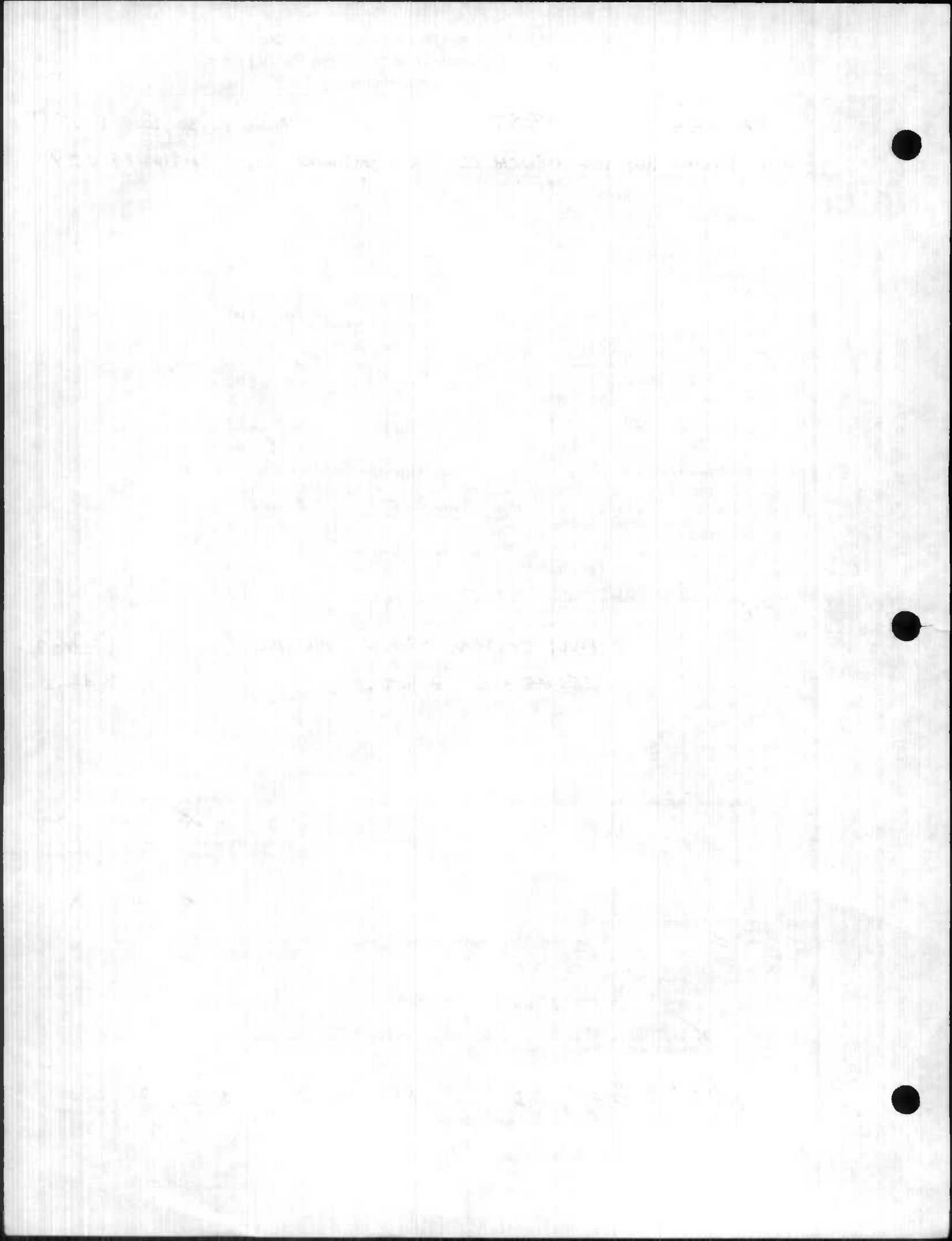
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27893

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Lillian Virginia Woods</i>				2. Date of Death Month: <i>August</i> Day: <i>28</i> Year: <i>2000</i>		3. Time of Death <i>07:20 A.M.</i>			
	4a. Facility Name (If not institution, give street and number) <i>Sinai Hospital</i>				4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>N/A</i>			
Funeral Director	5. Social Security Number <i>216-42-2591</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>56</i> Yrs.		8. Date of Birth Month: <i>Nov.</i> Day: <i>19</i> Year: <i>1943</i>		9. Birthplace (State or Foreign Country) <i>Maryland</i>	
	Usual Residence of Decedent 10a. State: <i>Maryland</i> 10b. County: <i>N/A</i> 10c. City, Town or Location: <i>BALTIMORE</i>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number <i>5510 Lynview Ave</i>				10f. Zip Code <i>21215</i>		10g. Citizen of What Country? <i>USA</i>				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): <i>12th grade</i> College (1-4 or 5+):				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Housewife</i>		16b. Kind of Business/Industry <i>Own Home</i>				
17. Father's Name (First, Middle, Last) <i>Alford Diggs</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Helen Sales</i>						
19a. Informant's Name/Relationship (Type, Print) <i>Edward Woods / son</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>5510 Lynview Ave Baltimore, Md 21215</i>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify):		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Harmon Forest Veterans Cemetery</i>		20c. Location - City or Town, State <i>Owings Mills, Md</i>						
21. Signature of Funeral Service Licensee <i>Debra Harris</i>		22. Name and Address of Facility <i>CHATHAM - Harmon Funeral Home 5240 RAISTERSTOWN ROAD BALTIMORE, MD 21215</i>								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <i>Hypertensive Atherosclerotic Cardiovascular Disease</i>  Due to (or as a consequence of): <i>Cardiovascular Disease</i>  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Asthma</i>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <b>Inspection</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <i>O.C.M.E.</i>		29d. Date signed (Month, Day, Year) <i>August 28, 2000</i>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>J. Laron Locke M.D. 111 Penn Street, Baltimore, Maryland 21201</i>										
31. Date filed (Month, Day, Year) <i>SEP 05 2000</i>		32. Registrar's Signature <i>[Signature]</i>								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27894

Jane B. Wadlin 9/1/00 6:30 p.m.  
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Jane Bogart Wadlin</b>				2. Date of Death Month Day Year <b>SEPT 1, 2000</b>		3. Time of Death <b>6:30pm</b>
	4a. Facility Name (If not institution, give street and number) <b>Oak Lodge Senior Home</b>			4b. City, Town, or Location of Death <b>Pasadena</b>		4c. County of Death <b>Anne Arundel</b>	
Funeral Director	5. Social Security Number <b>494-14-8479</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>79 Yrs.</b>	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>NOV 9, 1920</b>	9. Birthplace (State or Foreign Country) <b>Missouri</b>
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State <b>Maryland</b>	10b. County <b>Anne Arundel</b>	10c. City, Town or Location <b>Pasadena</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>515 Edgewater Road</b>			10f. Zip Code <b>21122</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Housewife</b>			16b. Kind of Business/Industry <b>Nurturing</b>	
	17. Father's Name (First, Middle, Last) <b>Franklin Davis Bogart</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Irene Ball Nave</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Kenneth L. Wadlin/son</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>515 Edgewater Road Pasadena, MD 21122</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory, Inc.</b>		Date <b>9/2/00</b>	20c. Location - City or Town, State <b>Baltimore, MD</b>	
	21. Signature of Funeral Service Licensee <b>Dawn F. McDonald</b>			22. Name and Address of Facility <b>Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. dehydration</b> Due to (or as a consequence of): <b>b. multiinfarct dementia</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						
Physician /Medical Examiner	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						
	24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Assisted Living</b>						
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred				
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
State Registrar	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
	29b. Signature and title of certifier <b>Jane B. Wadlin</b>		29c. License number <b>D8387</b>		29d. Date signed (Month, Day, Year) <b>9/2/00</b>		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>J. Benjamin, M.D. 4799 Jumpers Hole Rd. # 304 Severn Park, MD 21146</b>						
31. Date filed (Month, Day, Year) <b>SEP 5 2000</b>		32. Registrar's Signature <b>J. Benjamin</b>					


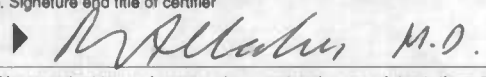
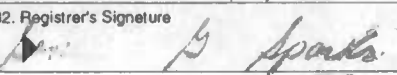




Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27895  
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ROBERT JAMES WHITE</b>				2. Date of Death Month <b>AUGUST</b> Day <b>31</b> Year <b>2000</b>		3. Time of Death <b>3:00 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>GOOD SAMARITAN HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>215566959</b>		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>48</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>12-27-51</b>	
	9. Birthplace (State or Foreign Country) <b>BALTIMORE</b>		10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number <b>1818 ARGON DRIVE APT.H</b>		10f. Zip Code <b>21218</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>(DISABLE)</b>		16b. Kind of Business/Industry <b>NONE</b>		17. Father's Name (First, Middle, Last) <b>ROBERT JAMES WHITE SR.</b>		
18. Mother's Name (First, Middle, Maiden Surname) <b>Ruby Mae Plater</b>		19. Informant's Name/Relationship (Type, Print) <b>RUBY MAE WHITE, MOTHER</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3008 OAKFORD AVE, BALTIMORE, MD 21215</b>		20. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		
20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MOUNT ZION CEMETERY</b>		20c. Date <b>9-7-00</b>		20d. Location - City or Town, State <b>LANDSDOWNE, MD</b>		21. Signature of Funeral Service Licensee 		
22. Name and Address of Facility <b>HOWELL FUNERAL HOME 4600 LIBERTY HIGHTS AVE, BALTO. MD 21207</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>ADULT RESPIRATORY DISTRESS SYNDROME</b> Due to (or as a consequence of):  b. <b>MULTI ORGAN FAILURE</b> Due to (or as a consequence of):  c. <b>SEPSIS</b> Due to (or as a consequence of):  d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>LIVER FAILURE</b>  <b>KIDNEY FAILURE</b>		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>12-27-51</b>		28b. Time of Injury <b>M</b>		
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier  <b>M.D.</b>		29c. License number <b>P 12555</b>		29d. Date signed (Month, Day, Year) <b>AUGUST 31, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>RAMIN ALTAHA, M.D. GOOD SAMARITAN HOSPITAL, 5601 LOCH AVEEN BOULEVARD, MD 21239</b>		31. Date filed (Month, Day, Year) <b>SEP - 5 2000</b>		32. Registrar's Signature 		33. Registrar's Title <b>BALTIMORE</b>		

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27896

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Ida Delores Williams

2. Date of Death

September 1, 2000 6:00 AM

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Mariner Health of Catonsville

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

Baltimore

5. Social Security Number

218-22-7639

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

JAN 16, 1926

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Perry Hall

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6701 Old Forge Lane

10f. Zip Code

21236

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

11th

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

William Wallace

18. Mother's Name (First, Middle, Maiden Surname)

Ida Baysmore

19a. Informant's Name (Relationship Type, Print)

Gloria May - daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6701 Old Forge Lane Perry Hall, MD 21236

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

King Mem. Park

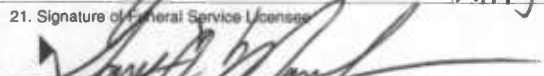
Date

9-6-00

20c. Location - City or Town, State

Randallstown, MD

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Gary P. March Funeral Home P.A.  
270 Fredhillon Pass Balto., MD. 21229

23a. Part I. Underlying disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or asphyxia. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Cerebral Thrombosis

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No


28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D15872

29d. Date signed (Month, Day, Year)

September 5 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HAROLD BOB 25 MAM ST REIDERSBURG 21136

31. Date filed (Month, Day, Year)

SEP 5 2000

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27897

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>WELDON S. WERTZ JR.</b>				2. Date of Death Month <b>SEPTEMBER</b> Day <b>1</b> Year <b>2000</b>		3. Time of Death <b>9:00am</b>	
	4a. Facility Name (If not institution, give street and number) <b>FRANKLIN WOODS</b>				4b. City, Town, or Location of Death <b>ROSEDALE</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>215 34 1590</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>65</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>March 29, 1935</b>	
	9. Birthplace (State or Foreign Country) <b>PENNSYLVANIA</b>		10a. State <b>MD</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>RASPEBURG</b>	
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number <b>5934 DAYBREAK TERRACE</b>				10f. Zip Code <b>21206</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1954</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>PROJECT MANAGER</b>		16b. Kind of Business/Industry <b>ENGINEERING</b>			
	17. Father's Name (First, Middle, Last) <b>WELDON S. WERTZ SR.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>MARY FLICK</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>ROBERTA L. WERTZ/WIFE</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5934 DAYBREAK TERRACE BALTIMORE, MD 21206</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>METRO CREMATORY</b>		Date <b>9/5/00</b>		20c. Location - City or Town, State <b>BALTIMORE, MD</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE BALTIMORE, MD 21237</b>			
	23a. Pertinent illness, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Transistional Cell Bladder Carcinoma</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>				Approximate Interval Between Onset and Death <b>13 Months</b>			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier M.D.		29c. License number <b>D45390</b>		29d. Date signed (Month, Day, Year) <b>9/5/00</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MYO MEN (M.D.) GREGG HOSPITAL SR. # 200, BALTIMORE, MD 21237</b>								
31. Date filed (Month, Day, Year) <b>SEP 5 2000</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





00-4926-510

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

DELVON

State of Maryland / Department of Health and Mental Hygiene

00 27898

ALEXANDER

amend item 23a,27 per me G789 11/2/00 yf

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Delvon S. Alexander, Jr.</b>				2. Date of Death Month <b>AUGUST</b> Day <b>30</b> Year <b>2000</b>		3. Time of Death <b>9:40P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>JOHNS HOPKINS HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>NA</b>	
Funeral Director	5. Social Security Number <b>NA</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. <b>2</b> Months <b>28</b> Days		8. Date of Birth (Month, Day, Year) <b>06-01-2000</b>	
	Usual Residence of Decedent		9. Birthplace (State or Foreign Country) <b>MD</b>		10a. State <b>MD</b>		10b. County <b>NA</b>	
10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>1024 N. Durham Street</b>		
10f. Zip Code <b>21205</b>				10g. Citizen of What Country? <b>USA</b>		11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		
12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>Infant</b> College (1-4or 5+) <b>NA</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Infant</b>		16b. Kind of Business/Industry <b>Infant</b>		
17. Father's Name (First, Middle, Last) <b>Delvon Shawn Alexander</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Cheryl Renee Thomas</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Carolyn Sherden</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1024 N. Durham Street Baltimore, MD 21205</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Voshell Mem. Gardens</b>		20c. Location - City or Town, State <b>09-07-2000 Dundalk, MD</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Baltimore, Maryland 21202</b> <b>WM.C.March FH 1101 E. North Avenue</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>SUDDEN INFANT DEATH SYNDROME</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. Signature and title of certifier 				29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>AUGUST 31, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JACK M. TITUS, M.D. 111 Penn Street, Baltimore, Maryland 21201</b>								
31. Date filed (Month, Day, Year) <b>SEP 06 2000</b>				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27899

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CONSTANCE Alston

2. Date of Death

Month Day Year  
Aug. 29 2000

3. Time of Death

10:05 AM

4a. Facility Name (If not institution, give street and number)

Bon Secours Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

n/a

Funeral  
Director

5. Social Security Number

220-24-9078

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 14, 1928

9. Birthplace (State or Foreign Country)

NC

Usual Residence of Decedent

10a. State

Md.

10b. County

n/a

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

2901 Keyworth Avenue

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th Grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Registered Nurse

16b. Kind of Business/Industry

Walter P. Carter Center

17. Father's Name (First, Middle, Last)

Booker T. Nesbit

18. Mother's Name (First, Middle, Maiden Surname)

Marie Douglas

19a. Informant's Name/Relationship (Type, Print)

Craig Alston son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5400 Dogwood Road Baltimore, Md. 21207

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arbutus Memorial Park

Date

Sept. 2

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

Brendon McNair

22. Name and Address of Facility

Nutter Funeral Homes, Inc.  
2501 Gwynns Falls PKWY Baltimore, Md. 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. DISSEMINATED INTRAVASCULAR COAGULOPATHY

24 hours

Due to (or as a consequence of):

b. LOWER GI. BLEEDING

30 days

Due to (or as a consequence of):

c. DIFFUSE DIVERTICULAR DISEASE OF COLON.

YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ASCVD - HYPERTENSION

LIPIDEMIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

B. McNair, MD

29c. License number

D16333

29d. Date signed (Month, Day, Year)

8/24/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ERNESTO MOLFINO, MD 3450 ELLICOTT CTR DR SUITE 105

ELLICOTT CITY, MD 21043

31. Date filed (Month, Day, Year)

SEP 6 2000

32. Registrar's Signature

B. Sparks

State  
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

100-100

100-100

100-100

100-100

100-100

100-100

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100-100

100-100

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27900

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CLEOFAS C. AGDEPPA				2. Date of Death Month Day Year SEPT. 2, 2000				3. Time of Death 9:50 P.M.	
	4a. Facility Name (If not institution, give street and number) JOSEPH RICHEY HOSPICE				4b. City, Town, or Location of Death BALTIMORE CITY				4c. County of Death BALTIMORE CITY	
Funeral Director	5. Social Security Number 220-29-2488		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.		8. Date of Birth (Month, Day, Year) SEPT. 25, 1920		9. Birthplace (State or Foreign Country) PHILIPPINES	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MARYLAND		10b. County BALTIMORE COUNTY		10c. City, Town or Location MIDDLE RIVER				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 21 Pocasset Ct.				10f. Zip Code 21220		10g. Citizen of What Country? UNITED STATES			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: FILIPPINO		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College 4 (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TEACHER				16b. Kind of Business/Industry EDUCATION	
	17. Father's Name (First, Middle, Last) SERAPION AGDEPPA				18. Mother's Name (First, Middle, Maiden Surname) EZPERANZA CONTRERAS					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) JOVITA AGDEPPA / WIFE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21 POCASSET CT., BALTIMORE, MARYLAND 21220					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) METRO CREMATORY, INC.		Date SEPT. 8 2000		20c. Location - City or Town, State CATONSVILLE, MARYLAND			
	21. Signature of Funeral Service Licensee				22. Name and Address of Facility KIRLKEY-RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>HEPATOCELLULAR CARCINOMA</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No									
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <u>HOSPICE</u>					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)										
28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier				29c. License number D001949				29d. Date signed (Month, Day, Year) SEPTEMBER 3, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W J DANA H. GRIFITHS, MD 900 CATON AVE. BALTIMORE, MD 21209										
State Registrar	31. Date filed (Month, Day, Year) SEP 06 2000				32. Registrar's Signature <u>[Signature]</u>					

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27901

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Anastasios N. Bassimakopoulos</b>				2. Date of Death Month <b>08</b> Day <b>28</b> Year <b>2000</b>		3. Time of Death <b>4:20 a.m.</b>		
	4a. Facility Name (If not institution, give street and number) <b>304 Oldham Street</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>		
Funeral Director	5. Social Security Number <b>149-74-5408</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>49</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>10 01 1950</b>		
	9. Birthplace (State or Foreign Country) <b>Greece</b>		10a. State <b>Md</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>304 Oldham Street</b>		10f. Zip Code <b>21224</b>		10g. Citizen of What Country? <b>Greece</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Cook</b>		16b. Kind of Business/Industry <b>Restaurant</b>					
17. Father's Name (First, Middle, Last) <b>(Unknown)</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Maria (Unknown)</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Friend</b> <b>Elizabeth Pirovolikos</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>304 Oldham Street, Baltimore, Md. 21224</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Oaklawn Cemetery</b>		20c. Date <b>08/30</b>		20d. Location - City or Town, State <b>Baltimore, Md.</b>			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Bradley-Ashton-Matthews Funeral Home, Inc</b> <b>2134 Willow Spring Road, Balto, Md 21222</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. METASTATIC NON-SMALL CELL LUNG CANCER 18 mos</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier 				29c. License number <b>D33551</b>		29d. Date signed (Month, Day, Year) <b>August 29, 2000</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MICHAEL AUERBACK, 9000 FRANKLIN SQ D, BETHESDA 20837</b>									
31. Date filed (Month, Day, Year) <b>SEP 06 2000</b>				32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Angie Bayoumi</b>		2. Date of Death Month Day Year <b>SEPTEMBER 3, 2000</b>		3. Time of Death <b>2000 PM</b>
	4a. Facility Name (If not institution, give street and number) <b>JOHNS HOPKINS HOSPITAL</b>		4b. City, Town, or Location of Death <b>BALTIMORE CITY</b>		4c. County of Death
Funeral Director	5. Social Security Number <b>216-47-0824</b>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>4</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>06 10 96</b>		9. Birthplace (State or Foreign Country) <b>M.D.</b>		
Usual Residence of Decedent					
10a. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
10e. Street and Number <b>3204 East Fairmount</b>			10f. Zip Code <b>21224</b>		10g. Citizen of What Country? <b>U.S.A.</b>
11. Marital Status <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No Specify: <b>Egyptian</b>	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>NA</b> College (1-4or 5+) <b>NA</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>NA</b>		16b. Kind of Business/Industry <b>NA</b>	
17. Father's Name (First, Middle, Last) <b>Asem Bayoumi</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Amany F. Elsigai</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Asem Bayoumi-Father</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3204 East Fairmount, Baltimore Md 21224</b>		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>King Memorial Park</b>		20c. Location - City or Town, State <b>9/5/2000 Randallstown, Md</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>March F/H West 4300 Wabash Ave, Baltimore, Md 21215</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. DROWNING</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <b>INSPECTION</b> 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		28. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) <b>9-1-00</b>		28b. Time of Injury <b>18:31 PM</b>	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>SUBJECT DROWNED</b>		28e. Location (Street and Number or Rural Route Number, City or Town, State) <b>7677 LILLIAN HOLT RD BALTIMORE MD</b>	
28f. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>SWIMMING POOL (PUBLIC)</b>					
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>OCME</b>	
29d. Date signed (Month, Day, Year) <b>SEPTEMBER 4, 2000</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>HAROLD A. KOSOW 111 Penn Street, Baltimore, Maryland 21201</b>					
31. Date filed (Month, Day, Year) <b>SEP 06 2000</b>		32. Registrar's Signature 			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27903

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIAM JEFFERSON BROOKS, SR.				2. Date of Death Month Day Year September 3, 2000				3. Time of Death 6:25 A.M.	
	4a. Facility Name (If not institution, give street and number) VAMHCS FORT HOWARD DIVISION				4b. City, Town, or Location of Death FORT HOWARD				4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 219-10-5268		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 74 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) Jan. 02 1926		9. Birthplace (State or Foreign Country) Maryland		10a. State Md.		10b. County n/a		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 411 Pontiac Ave.				10f. Zip Code 21225		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: white	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (1-4 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Foreman				16b. Kind of Business/Industry EBE Dist. and Construction Company	
	17. Father's Name (First, Middle, Last) Willard Brooks				18. Mother's Name (First, Middle, Maiden Surname) Irene Clough					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Rickey Brooks (Son)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1359 Hull Street Apt. 1 Rear, Baltimore, Md. 21230					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Memorial Park				20c. Location - City or Town, State 9/07/2000 Glen Burnie, Md.	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 237 E. Patapsco Ave. Baltimore, Md. 21225				Approximate Interval Between Onset and Death	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. RECTAL CANCER Due to (or as a consequence of): b. RENAL CANCER Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								10 MOS 9 MOS	
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
					24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				28d. Describe how injury occurred	
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 				29c. License number D52739	
To Be Completed by Physician/Medical Examiner	29d. Data signed (Month, Day, Year) Sept 3, 2000				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURESH SHANDELYA, M.D. 9600 NORTH POINT ROAD, FORT HOWARD, MD 21052					
	31. Date filed (Month, Day, Year) SEP 06 2000				32. Registrar's Signature 					

ORIGINAL





Herbert Breeden

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #23 PART I, 27, 28A-F

PER MEO G187 9-13-00 WR.

Certificate of Death

Reg. No.

00 27904

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Herbert A. Breeden						2. Date of Death Month Day Year August 29 2000		3. Time of Death 03:25 P.M.		
	4a. Facility Name (If not Institution, give street and number) 607 Smith Street				4b. City, Town, or Location of Death Salisbury		4c. County of Death Wicomico				
Funeral Director	5. Social Security Number 220-76-2583		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 37 Yrs.		8. Date of Birth (Month, Day, Year) May 28, 1963		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent										
10a. State Maryland			10b. County Wicomico		10c. City, Town or Location Salisbury			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number 607 Smith Street					10f. Zip Code 21801		10g. Citizen of What Country? United States				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bricklayer			16b. Kind of Business/Industry Construction			
17. Father's Name (First, Middle, Last) George Breeden					18. Mother's Name (First, Middle, Maiden Surname) Mary M. Austerman						
19a. Informant's Name/Relationship (Type, Print) Mary M. Hailey - Mother					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1156 Carroll Street, Baltimore, Maryland 21230						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park Cemetery			Date 9-2-00		20c. Location - City or Town, State Baltimore, Maryland			
21. Signature of Funeral Service Licensee <i>Lisa S. Jefferson</i>					22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Avenue, Baltimore, Maryland 21229						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  NARCOTIC INTOXICATION  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
										24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
										24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Scene								
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined			28a. Date of injury (Month, Day, Year) 8-28-00		28b. Time of injury UNKNOWN		28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred UNKNOWN		
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) FOUND: HOME					28f. Location (Street and Number or Rural Route Number, City or Town, State) 607 SMITH ST SALISBURY, WICOMICO CO. MD						
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										29c. License number O.C.M.E.	
29b. Signature and title of certifier <i>Stephen S. Radentz, M.D.</i>					29d. Date signed (Month, Day, Year) August 30, 2000						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201											
31. Date filed (Month, Day, Year) SEP 06 2000			32. Registrar's Signature <i>Barbara B. Sparks</i>								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27905

AMEND#20B&amp;20C PER F.H. G787 9-7-2000 JAB

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Ronald Curtis</b>		2. Date of Death Month: <b>September</b> Day: <b>04</b> Year: <b>2000</b>		3. Time of Death <b>06:47</b>
	4a. Facility Name (If not institution, give street and number) <b>The Johns Hopkins Hospital</b>		4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>NA</b>
Funeral Director	5. Social Security Number <b>217-68-1784</b>	6. Sex <b>MALE</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>43</b> Yrs.	If Under 1 Year Months: <b>0</b> Days: <b>0</b>	If Under 24 Hrs. Hours: <b>0</b> Min: <b>0</b>
	8. Date of Birth (Month, Day, Year) <b>6/25/57</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
Usual Residence of Decedent					
10a. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>BALTIMORE</b>	
10e. Street and Number <b>4334 Parkside Drive</b>			10f. Zip Code <b>21206</b>		10g. Citizen of What Country? <b>USA</b>
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): <b>12th</b> College (1-4 or 5+): <b>NA</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>laborer</b>		16b. Kind of Business/Industry <b>Construction</b>
17. Father's Name (First, Middle, Last) <b>Sidney Curtis</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Thelma Baker</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Vernita Cox / Sister</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4334 Parkside Dr. Balto, MD 21206</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MT. ZION CEMETERY</b>		20c. Location - City or Town, State <b>LANSOWNE, MD</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Wyllie Funeral Home, P.A. 638 N. Gilmer St. Baltimore, MD 21207</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		a. <b>Hypovolemic shock</b> Due to (or as a consequence of):			Approximate Interval Between Onset and Death <b>25 minutes</b>
		b. <b>acute blood loss</b> Due to (or as a consequence of):			<b>30 minutes</b>
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		c. <b>Cavity Left Lung Pseudomonas Pneumoniae</b> Due to (or as a consequence of):			<b>2 weeks</b>
		d.			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>AIDS</b>					
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> 4 <input type="checkbox"/> Nursing Home <input type="checkbox"/> 5 <input type="checkbox"/> Residence <input type="checkbox"/> 8 <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier MD		29c. License number <b>RES - 000</b>		29d. Date signed (Month, Day, Year) <b>September 04, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Derek Taylor 600 North Wolfe Street, Baltimore, Maryland 21287</b>					
31. Date filed (Month, Day, Year) <b>SEP 06 2000</b>		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



asp

Richard Earl Chew

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27906

AMEND ITEMS: #23 PART I, 27, 28A-F PER MED G7879-11-00 WR

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Richard E. Chew</b>		2. Date of Death Month Day Year <b>AUGUST 29 2000</b>		3. Time of Death <b>11:23 A</b>
	4a. Facility Name (If not institution, give street and number) <b>501 E. PRATT ST. PIER # 3</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>NA</b>
Funeral Director	5. Social Security Number <b>220-82-2670</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>38</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>09-30-61</b>	9. Birthplace (State or Foreign Country) <b>MD</b>
	Usual Residence of Decedent				
10a. State <b>MD</b>		10b. County <b>NA</b>	10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number <b>1255 Lindenleaf Court</b>		10f. Zip Code <b>21202</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10th Grade</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Laborer</b>	
16b. Kind of Business/Industry <b>Construction Co.</b>		17. Father's Name (First, Middle, Last) <b>Lee W. Chew, Sr.</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Jeanette Alston</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Jeanette Chew</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21202 1255 Linden Leaf Court Baltimore, Maryland</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Greenmount Cemetery</b>		20c. Location - City or Town, State <b>09-06-2000 Baltimore, MD</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>DROWNING</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Due to (or as a consequence of):</b>  <b>Due to (or as a consequence of):</b>  <b>Due to (or as a consequence of):</b>  <b>Due to (or as a consequence of):</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b>		27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined			
28a. Date of Injury (Month, Day, Year) <b>8-29-00</b>		28b. Time of Injury <b>11:15</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred <b>UNKNOWN</b>		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>FOUND IN WATER</b>			
28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>PIER #3, 501 E. MD. PRATT ST, BALTO. CITY, MD.</b>		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. Signature and title of certifier  <b>Joseph Pestaner, M.D.</b>		29c. License number <b>O.C.M.E</b>		29d. Date signed (Month, Day, Year) <b>AUGUST 30, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>111 Penn Street, Baltimore, Maryland 21201</b>					
31. Date filed (Month, Day, Year) <b>SEP 06 2000</b>		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27907

Amended Item #18 per FHG787 9/15/2000 EW

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Charlotte Myra Cottman				2. Date of Death Month Day Year September 5, 2000		3. Time of Death 1:25 PM	
	4a. Facility Name (If not institution, give street and number) Levindale Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death	
Funeral Director	5. Social Security Number 218-36-7090		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 62 Yrs.		8. Date of Birth (Month, Day, Year) 02/07/1938	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Baltimore	
10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 6980 Marsue Drive Apt. T2		10f. Zip Code 21215		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cafeteria Aid		16b. Kind of Business/Industry School				
17. Father's Name (First, Middle, Last) William Edward Racusin		18. Mother's Name (First, Middle, Maiden Surname) Faye Blackman Fay Blechman		19a. Informant's Name/Relationship (Type, Print) Charles Cottman / Husband		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6980 Marsue Drive Apt. T2 Baltimore, Maryland 21215		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion Cemetery		20c. Location - City or Town, State 09/08/00 Landsdowne, Maryland		21. Signature of Funeral Service Licensee		
22. Name and Address of Facility Derrick C. Jones Funeral Home 4611 Park Heights Ave., Baltimore, Maryland 21215		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of death. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): b. Cerebrovascular Disease Due to (or as a consequence of): c. Due to (or as a consequence of): d.		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		
28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Debra Shwertheimer MD		
29c. License number D23767		29d. Date signed (Month, Day, Year) September 5, 2000		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Debra Shwertheimer MD 2434 W. Belvedere Ave, Balto, MD 21215		31. Data filed (Month, Day, Year) SEP 06 2000		
32. Registrar's Signature B. Sparks		33. State Registrar		34. DHMH 16 Rev 6/95		ORIGINAL		

Baltimore, Maryland 21215-0020

perm. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Charlotte Cottman

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27908

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ANGELINA CATANZARO</b>				2. Date of Death Month Day Year <b>September 02, 2000</b>		3. Time of Death <b>1830 pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>Johns Hopkins Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>011-01-1657</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>82</b>	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>8/16/18</b>	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>	
	Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>2725 LOUISE AVENUE</b>				10f. Zip Code <b>21214</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9th GRADE</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SEAMSTRESS</b>		16b. Kind of Business/Industry <b>DAROFFS</b>		
17. Father's Name (First, Middle, Last) <b>ROCCO CATANZARO</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>JENNIE SALMARI</b>				
19a. Informant's Name/Relationship (Type, Print) <b>SALVATORE CATANZARO/BROTHER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1336 HALSTEAD ROAD BALTIMORE, MD 21234</b>				
20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GARDENS OF FAITH CEM.</b>		Date <b>9/6/00</b>		20c. Location - City or Town, State <b>PARKVILLE, MD</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>JOHNSON FUNERAL HOME P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>Chest Injuries</b> Due to (or as a consequence of): a. _____ b. _____ c. _____ d. _____ Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Approximate Interval Between Onset and Death								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) <b>9/2/00</b>		28b. Time of Injury <b>5:45pm</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Street</b>		28e. Describe how injury occurred <b>Driver of Vehicle Collides with another vehicle</b>						
28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>6000 Black Old Harbor Road, Baltimore, Md</b>								
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier  <b>Joseph Pestaner MD</b>				29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>September 03, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201</b>								
31. Date filed (Month, Day, Year) <b>SEP 06 2000</b>				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27909

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Willie James Canty, Sr.</b>				2. Date of Death Month Day Year <b>September 4 2000</b>		3. Time of Death <b>1:40 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Franklin Square Hospital Center</b>				4b. City, Town, or Location of Death <b>Rosedale</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>144-34-5981</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>55</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>May 14, 1945</b>		9. Birthplace (State or Foreign Country) <b>NC</b>
	Usual Residence of Decedent							
10a. State <b>Md.</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Essex</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>1111 Sandy Stone Road Apt. G</b>				10f. Zip Code <b>21221</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 10th Grade</b> <b>College (1-4 or 5+)</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Salesman/Printer Professional Self Employed</b>		16b. Kind of Business/Industry		
17. Father's Name (First, Middle, Last) <b>James Hands</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Alberta Canty</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Willie Canty, Jr. son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9100 E. Tumble Weed Run Laurel, Md. 20723</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Zion Cemetery</b>		Data <b>Sept. 8</b>		20c. Location - City or Town, State <b>Lansdowne, Md.</b>		
21. Signature of Funeral Service Licensee <b>James R. Perry, Jr.</b>				22. Name and Address of Facility <b>Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Intracerebral Hemorrhage</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>John Coffey (Coffey)</b>		29c. License number <b>D0055-010</b>		29d. Date signed (Month, Day, Year) <b>September 4, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>John Coffey MD. 9000 Franklin Square Drive Baltimore Maryland 21237</b>								
31. Date filed (Month, Day, Year) <b>SEP 6 2000</b>		32. Registrar's Signature <b>B. Sparks</b>						

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27910

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HAZEL VIRGINIA CALVERT</b>				2. Date of Death Month Day Year <b>SEPTEMBER 04 2000</b>		3. Time of Death <b>3:05 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>GENESIS ELDERCARE HAMMONDS LANE</b>				4b. City, Town, or Location of Death <b>BROOKLYN PARK</b>		4c. County of Death <b>ANNE ARUNDEL COUNTY</b>	
Funeral Director	5. Social Security Number <b>219-16-3518</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>82</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>May 14 1918</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent				10a. State <b>Md.</b>		10b. County <b>n/a</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number <b>1409 Webster Street</b>		10f. Zip Code <b>21230</b>		10g. Citizen of What Country? <b>USA</b>
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>0</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Sales Person</b>		16b. Kind of Business/Industry <b>Butler Brothers</b>		
17. Father's Name (First, Middle, Last) <b>William Koerber</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Frances Wood</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Edward G. Calvert (Son)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>203 Oakleaf Way Baltimore, Md. 21227</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cedar Hill Cemetery</b>		Date <b>9/07/2000</b>		20c. Location - City or Town, State <b>Baltimore, Md.</b>	
21. Signature of Funeral Service Licensee <i>Richard Roberts</i>				22. Name and Address of Facility <b>McCully-Polyniak Funeral Home P.A. 237 E. Patapsco Ave. Baltimore, Md. 21225</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Respiratory Insufficiency</b> Due to (or as a consequence of): <b>Chronic Obstructive Pulmonary Disease</b> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Hypertension Atherosclerotic Coronic Vascular Disease</b>								Approximate Interval Between Onset and Death <b>3 mos</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension Atherosclerotic Coronic Vascular Disease</b>								23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29b. Signature and title of certifier <i>Alan Neal Dennis</i>
29c. License number <b>D30515</b>				29d. Date signed (Month, Day, Year) <b>September 6, 2000</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Alan Neal Dennis, 901 East Fort Avenue, Baltimore, MD 21230</b>								
31. Date filed (Month, Day, Year) <b>SEP 06 2000</b>				32. Registrar's Signature <i>Benjamin Sparks</i>				

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27911

AMENDED ITEM #20b PER FH G787 9/6/00 AH

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Bernadine Elizabeth Cochran</b>				2. Date of Death Month <b>Sept.</b> Day <b>3</b> Year <b>2000</b>		3. Time of Death <b>6:15 a.m.</b>	
	4a. Facility Name (If not institution, give street and number) <b>145 Chestnut Hill Lane</b>				4b. City, Town, or Location of Death <b>Reisterstown</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>215-32-9703</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>64</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>April 8, 1936</b>	
	10a. State <b>Md.</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Reisterstown</b>		10d. Inland City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Housewife</b>		16b. Kind of Business/Industry <b>Homemaker</b>		
17. Father's Name (First, Middle, Last) <b>George Fleckenstein</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Jean Goldys</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Stanley Lee Cochran - Husband</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>145 Chestnut Hill Lane, Reisterstown, Md. 21136</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b></b>				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. John R.C. Cemetery</b>		20c. Location - City or Town, State <b>Hyde, Maryland</b>		
21. Signature of Funeral Service Licensee <b>H. Ehlhardt</b>				22. Name and Address of Facility <b>Eckhardt Funeral Chapel 11605 Reisterstown Rd., Owings Mills, Md. 21117</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Malignant brain tumor</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>				Approximate Interval Between Onset and Death				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>None Known</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b></b>				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year) <b></b>		28b. Time of Injury <b>M</b>		
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28d. Describe how injury occurred <b></b>				
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b></b>				28f. Location (Street and Number or Rural Route Number, City or Town, State) <b></b>				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <b>Howard Saint, M.D.</b>				
29c. License number <b>D15552</b>				29d. Date signed (Month, Day, Year) <b>9/4/00</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Howard Saint, M.D. 555 S. Center St. Westminster, Md. 21157</b>				31. Date filed (Month, Day, Year) <b>SEP 06 2000</b>				
32. Registrar's Signature <b>Sparks</b>				33. State Registrar <b>SEP 06 2000</b>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 00 27912

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Spina/ba DeGregorio

2. Date of Death

Month Day Year  
Sept 1, 2000

3. Time of Death

7:35 pm

4a. Facility Name (If not institution, give street and number)

5805 Queens Chapel Road

4b. City, Town, or Location of Death

Hyattsville

4c. County of Death

Prince Georges'

Funeral  
Director

5. Social Security Number

195-26-5151

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

98

8. Date of Birth

(Month, Day, Year)  
Feb. 18, 1902

9. Birthplace (State or Foreign Country)

Italy

Usual Residence of Decedent

10a. State

MD

10b. County

Prince Georges

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5805 Queens Chapel Road

10f. Zip Code

20782

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
6College (1-4 or 5+)  
0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Filippo Troilo

18. Mother's Name (First, Middle, Maiden Surname)

Maria Giuseppe Melchiorre

19a. Informant's Name/Relationship (Type, Print)

Nicodemo DeGregorio / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10709 Rippon Lodge Drive, Fairfax VA 22032

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holy Saviour Cemetery Sept 5, 2000 Bethlehem, PA

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Victor Doda

22. Name and Address of Facility

Charles L. Stevens Funeral Home, Inc.  
1501 East Fort Avenue, Baltimore Maryland 21230

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Dehydration

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 week

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Impaired Swallowing Function

Due to (or as a consequence of):

Many yrs

c. Vascular Dementia

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Osteoporosis, Bilateral Femur Fracture

Pressure Sores

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D31001

29d. Date signed (Month, Day, Year)

9/2/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stuart J. Turkewitz, M.D.

7500 Greenway Ctr. Dr. #430  
Greenbelt, MD. 20770

31. Date filed (Month, Day, Year)

SEP 06 2000

32. Registrar's Signature

Geneva P. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27913

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Ophelia Donaldson</b>		2. Date of Death Month <b>Sept.</b> Day <b>04</b> Year <b>2000</b>		3. Time of Death <b>2:40am</b>
	4a. Facility Name (If not institution, give street and number) <b>Genesis Elder Care-Hamilton</b>		4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>NA</b>
Funeral Director	5. Social Security Number <b>216-03-5378</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>83</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>08-26-16</b>		9. Birthplace (State or Foreign Country) <b>NC</b>		
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>
	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
	10e. Street and Number <b>5719 B. Cedonia Avenue</b>		10f. Zip Code <b>21206</b>		10g. Citizen of What Country? <b>USA</b>
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>				
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>6th Grade</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Domestic</b>		16b. Kind of Business/Industry <b>in &amp; out of home</b>
	17. Father's Name (First, Middle, Last) <b>William Shearin</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Johnnie Turner</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Ophelia Brown Carter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21206</b> <b>5719 B. Cedonia Avenue Baltimore, Maryland</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arbutus Mem. Pk. Cem.</b>		20c. Location - City or Town, State <b>09-08-2000 Arbutus, MD</b>
	21. Signature of Funeral Service Licensee <b>Bernard D. Johnson</b>		22. Name and Address of Facility <b>Baltimore, Maryland 21202</b> <b>WM.C.March FH 1101 E. North Avenue</b>		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Cerebrovascular accident</b> Due to (or as a consequence of): <b>Institutional colon</b> Due to (or as a consequence of): <b>Anaemia</b> Due to (or as a consequence of): <b>Degenerative Joint Disease</b>				Approximate Interval Between Onset and Death
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		
	28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
29b. Signature and title of certifier <b>Dave</b>		29c. License number <b>D 31464</b>		29d. Date signed (Month, Day, Year) <b>9/6/00</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>SHOAB A. GASHMI MD. 821 N. EUTAW St Suite 308 Balt. MD 21201</b>					
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 06 2000</b>		32. Registrar's Signature <b>[Signature]</b>		



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27914

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>OLGA DRINKS</b>				2. Date of Death Month Day Year <b>AUGUST 31, 2000</b>		3. Time of Death <b>3:33 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Saint Joseph Medical Center</b>				4b. City, Town, or Location of Death <b>Towson</b>		4c. County of Death <b>Baltimore</b>		
Funeral Director	5. Social Security Number <b>218-03-3405</b>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>82</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>DEC 1, 1917</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State <b>MARYLAND</b>	10b. County <b>BALTIMORE</b>	10c. City, Town or Location <b>LARNEY</b>			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number <b>8800 WALTHER BLVD. APT. 3416</b>				10f. Zip Code <b>21234</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 YRS.</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>EXECUTIVE SECRETARY</b>			16b. Kind of Business/Industry <b>BENDIX RADIO CORP.</b>			
	17. Father's Name (First, Middle, Last) <b>LYG MONT GAPSIS</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>ANNIE MAZIKIUTE</b>				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>SALVIN L. DRINKS</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8800 WALTHER BLVD. APT. 3416 LARNEY, MD. 21234</b>				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>PARKWOOD CEMETERY</b>		20c. Location - City or Town, State <b>2000 PARKVILLE, MARYLAND</b>		20d. Date <b>SEPT. 2</b>		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>EVANS CHAPEL OF MEMORIES 8800 HARFORD ROAD PARKVILLE, MARYLAND 21234</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>SEPSIS DUE TO INTRA ABDOMINAL INFECTIONS</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>ADULT RESPIRATORY DISTRESS SYNDROME</b> <b>RENAL FAILURE</b>  Approximate Interval Between Onset and Death <b>21 DAYS</b>								
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28a. Place of Injury - At home, farm, street, factory, office building, a/c. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 				29c. License number <b>D 26954</b>		29d. Date signed (Month, Day, Year) <b>08/31/2000</b>	
30. Name and address of person who completed cause of death (item 23a) (Type, Print) <b>FEMY CHHIM, M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204</b>									
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 06 2000</b>		32. Registrar's Signature 						

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 0000.

To Be Completed by Funeral Director

ORIGINAL



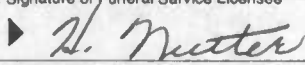


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27915

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Grace Duncan</b>				2. Date of Death Month <b>August</b> Day <b>27</b> Year <b>2000</b>				3. Time of Death <b>13:50</b>							
	4a. Facility Name (If not institution, give street and number) <b>Sinai Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>				4c. County of Death <b>n/a</b>							
Funeral Director	5. Social Security Number <b>217-38-3809</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>59</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.							
	8. Date of Birth (Month, Day, Year) <b>Oct. 30, 1940</b>		9. Birthplace (State or Foreign Country) <b>Md.</b>		10a. State <b>Md.</b>		10b. County <b>n/a</b>		10c. City, Town or Location <b>Baltimore</b>							
Usual Residence of Decedent																
10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No																
10e. Street and Number <b>3109 Gwynns Falls PKWY</b>					10f. Zip Code <b>21216</b>			10g. Citizen of What Country? <b>USA</b>								
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>								
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b> College (1-4 or 5+)					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Human Service Specialist</b>			16b. Kind of Business/Industry <b>Human Resources Department</b>								
17. Father's Name (First, Middle, Last) <b>Bernard L. Caesar</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Marie E. Hillery</b>											
19a. Informant's Name/Relationship (Type, Print) <b>Eddie Duncan husband</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3109 Gwynns Falls PKWY Baltimore, Md. 21216</b>											
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>New Cathedral Cemetery</b>		Date <b>Sept. 1</b>		20c. Location - City or Town, State <b>Baltimore, Md.</b>								
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216</b>											
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																
<table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last         </td> <td>a. <u>Cardiogenic Shock</u> Due to (or as a consequence of):</td> <td rowspan="4">Approximate Interval Between Onset and Death</td> </tr> <tr> <td>b. <u>Acute Myocardial Infarction</u> Due to (or as a consequence of):</td> </tr> <tr> <td>c. <u>Coronary Artery Disease</u> Due to (or as a consequence of):</td> </tr> <tr> <td>d. _____</td> </tr> </table>											Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. <u>Cardiogenic Shock</u> Due to (or as a consequence of):	Approximate Interval Between Onset and Death	b. <u>Acute Myocardial Infarction</u> Due to (or as a consequence of):	c. <u>Coronary Artery Disease</u> Due to (or as a consequence of):	d. _____
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. <u>Cardiogenic Shock</u> Due to (or as a consequence of):	Approximate Interval Between Onset and Death														
	b. <u>Acute Myocardial Infarction</u> Due to (or as a consequence of):															
	c. <u>Coronary Artery Disease</u> Due to (or as a consequence of):															
	d. _____															
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>S/P Coronary Artery Bypass Grafts X5</u>								23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			28. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)													
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred							
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier 				29c. License number <b>D-17635</b>		29d. Date signed (Month, Day, Year) <b>August 28, 2000</b>							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Luis A. Mispireta, Md. 3333 N. Calvert St. Baltimore, Md. 21218</b>																
31. Date filed (Month, Day, Year) <b>SEP 6 2000</b>			32. Registrar's Signature 													

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-358-0000.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit







00 27916

### Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Mard Davis</b>						2. Date of Death Month Day Year <b>September 5 2000</b>		3. Time of Death <b>5:45 A.M.</b>		
	4a. Facility Name (If not institution, give street and number) <b>5307 Patrick Henry Drive</b>						4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>Anne Arundel</b>		
Funeral Director	5. Social Security Number <b>246 48 2853</b>		6. Sex <b>1 M 2 F</b>		7. Age (In yrs. last birthday) <b>67</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>April 19, 1933</b>		9. Birthplace (State or Foreign Country) <b>North Carolina</b>		
	Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Anne Arundel</b> 10c. City, Town or Location <b>Baltimore</b> 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
To Be Completed by Funeral Director	10e. Street and Number <b>5307 Patrick Henry Drive</b>						10f. Zip Code <b>21225</b>		10g. Citizen of What Country? <b>U.S.</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>KOREAN WAR CONFLICT</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 8th</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Press Operator</b>		16b. Kind of Business/Industry <b>Chesapeake Box Company</b>						
	17. Father's Name (First, Middle, Last) <b>William Thomas Davis</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Gertrude Phillips</b>				
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Alberta J. Davis / Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5307 Patrick Henry Drive Baltimore, Maryland 21225</b>						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Glen Haven Memorial Park</b>		Date <b>9/8/00</b>		20c. Location - City or Town, State <b>Glen Burnie, Maryland</b>				
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225</b>						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>RESPIRATORY FAILURE</b> Due to (or as a consequence of): b. <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b> Due to (or as a consequence of): c. <b>AND CORONARY ARTERY DISEASE</b> Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death
Division of Vital Records, P.O. Box 68760,	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown		
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
									24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residencia <input type="checkbox"/> Other (Specify)								
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
State Registrar	29b. Signature and title of certifier 				29c. License number <b>D0052490</b>		29d. Date signed (Month, Day, Year) <b>9/5/00</b>				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Amit Khandelwal MD 3001, S. Hanover St. Baltimore MD 21225</b>										
	31. Date filed (Month, Day, Year) <b>SEP 06 2000</b>		32. Registrar's Signature 								

ORIGINAL




Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27917

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>KHAYA EYDELMAN</b>				2. Date of Death Month <b>SEPT</b> Day <b>2</b> Year <b>2000</b>		3. Time of Death <b>3:10AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>JEWISH CONVALESCENT &amp; NURSING HOME</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>BALTIMORE</b>		
Funeral Director	5. Social Security Number <b>217-25-5428</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>87</b> Yrs.		8. Date of Birth Month <b>MAY</b> Day <b>15</b> Year <b>1913</b>		
	9. Birthplace (State or Foreign) <b>UKRAINE</b>								
Usual Residence of Decedent									
10a. State <b>MD</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>BALTIMORE</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>7920 SCOTTS LEVEL ROAD</b>				10f. Zip Code <b>21208</b>		10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give X Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>PHARMACIST</b>			16b. Kind of Business/Industry <b>PHARMACY</b>		
17. Father's Name (First, Middle, Last) <b>UNKNOWN</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>UNKNOWN</b>					
19a. Informant's Name/Relationship (Type, Print) <b>MRS. SARRA ABRAMOVICH/DAUGHTER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5900 PARK HEIGHTS AVE#306 BALTIMORE, MD. 21215</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ARLINGTON-CHIZUK AMUNO CONGREGATION</b>		Date <b>9/4/00</b>		20c. Location - City or Town, State <b>BALTIMORE, MD.</b>			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS. INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD. 21208</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. MYOCARDIAL INFARCTION (PROBABLE) IMMEDIATE</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last									
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier  <b>MD</b>				29c. License number <b>115740</b>		29d. Date signed (Month, Day, Year) <b>SEPTEMBER 7, 2000</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>IAN SINSCHING 6210 KETS BLVD, BALTIMORE, MD 21215</b>									
31. Date filed (Month, Day, Year) <b>SEP 06 2000</b>				32. Registrar's Signature 					

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27918

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Cecil C. Ennis

2. Date of Death

Sept. 3 2000

3. Time of Death

7:00pm

4a. Facility Name (If not institution, give street and number)

9510 Burton Ave.

4b. City, Town, or Location of Death

Carney

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

225-18-9112

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 12, 1919

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Md

10b. County

Baltimore

10c. City, Town or Location

Carney

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9510 Burton Ave

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

12

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

self-employed

16b. Kind of Business/Industry

contractor

17. Father's Name (First, Middle, Last)

E. L. Ennis

18. Mother's Name (First, Middle, Maiden Surname)

Nora Jessie

19a. Informant's Name/Relationship (Type, Print)

Bernice A. Ennis wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9510 Burton Ave. Carney, Md 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Parkwood Cemetery

Date

Sept. 7 2000

20c. Location - City or Town, State

Parkville Maryland

21. Signature of Funeral Service Licensee

Heidi S. Wells

22. Name and Address of Facility

EVANS Funeral Chapel  
8800 Harford Rd Balto Md 2123423a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

Metastatic Prostate Cancer

a. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Aneurysm

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician2 ☐ Medical ExaminerTo the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner as stated.

29b. Signature and title of certifier

Heidi S. Wells MD

29c. License number

D32 984

29d. Date signed (Month, Day, Year)

9/6/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JEREMY WEINER 5601 Loch Raven Blvd. POB#100 21239

State  
Registrar

31. Date filed (Month, Day, Year)

SEP 06 2000

32. Registrar's Signature

Benjamin B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
0000.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,





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LEON EPPS, amend item ptII per me G789 11/14/00 yf  
amend item 23a, ptII, 27 per me G788 10/20/00 yf

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27919

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Leon Epps</i>		2. Date of Death Month Day Year <i>SEPTEMBER 2, 2000</i>		3. Time of Death <i>9:12 AM</i>
	4a. Facility Name (If not institution, give street and number) <i>FRANKLIN SQUARE HOSPITAL</i>		4b. City, Town, or Location of Death <i>ESSEX</i>		4c. County of Death <i>BALTIMORE</i>
Funeral Director	5. Social Security Number <i>214-72-7105</i>	6. Sex <i>1 M 2 F</i>	7. Age (In yrs. last birthday) <i>41</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <i>July 19, 1959</i>		9. Birthplace (State or Foreign Country) <i>Maryland</i>		
To Be Completed by Funeral Director	10a. State <i>Md.</i>		10b. County <i>Balto.</i>		10c. City, Town or Location <i>Essex</i>
	10d. Inside City Limits <i>1 Yes 2 No</i>				
	10e. Street and Number <i>2 Horse Chestnut Ct.</i>		10f. Zip Code <i>21221</i>		10g. Citizen of What Country? <i>U.S.A</i>
	11. Marital Status <i>1 Never Married 2 Married 3 Widowed 4 Divorced</i>		12. Was Decedent Ever in U.S. Armed Forces? <i>1 Yes 2 No</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <i>1 Yes 2 No</i>
	14. Race - American Indian, Black, White, etc. <i>Specify: Black</i>				
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12) 12</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Machine Operator</i>		16b. Kind of Business/Industry <i>Aeronautics</i>
	17. Father's Name (First, Middle, Last) <i>William H. Epps Sr.</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Margaret Griffin</i>		
	19a. Informant's Name/Relationship (Type, Print) <i>Charvonne Epps wife</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2 Horse Chestnut Ct. Balto Md 21221</i>		
	20a. Method of Disposition <i>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Dulaney Valley Cem.</i>		20c. Location - City or Town, State <i>9-8-2000 Balto. Md.</i>
	21. Signature of Funeral Service Licensee <i>Carlton C. Douglass</i>		22. Name and Address of Facility <i>Carlton C. Douglass Funeral Service 1701 Mc Culloch St. Balto. Md. 21217</i>		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death
	a. <i>HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</i> Due to (or as a consequence of):				
	b. Due to (or as a consequence of):				
	c. Due to (or as a consequence of):				
	d. Due to (or as a consequence of):				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <i>CHRONIC ALCOHOLISM</i>  <i>CAVITARY PNEUMONIA</i>					
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? <i>1 Yes 2 No 3 Probably 4 Unknown</i>		24a. Was an autopsy performed? <i>Yes 2 No</i>		
	24b. Were autopsy findings available prior to completion of cause of death? <i>Yes 2 No</i>				
	25. Was case referred to medical examiner? <i>1 Yes 2 No</i>		26. Place of Death (Check only one) Hospital: <i>1 Inpatient 2 Outpatient 3 DOA</i> Other: <i>4 Nursing Home 5 Residence 6 Other (Specify)</i>		
	27. Manner of Death <i>1 Natural 2 Accident 3 Suicide 4 Homicide</i>		28a. Date of Injury (Month, Day, Year) <i>28b. Time of Injury M</i>		
	28c. Injury at Work? <i>1 Yes 2 No</i>		28d. Describe how Injury occurred		
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <i>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</i> <i>2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</i>				
	29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <i>O.C.M.E.</i>		29d. Date signed (Month, Day, Year) <i>SEPTEMBER 3, 2000</i>
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Diabonkye...</i> <i>111 Penn Street, Baltimore, Maryland 21201</i>				
	31. Date filed (Month, Day, Year) <i>SEP 06 2000</i>		32. Registrar's Signature <i>[Signature]</i>		

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

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Handwritten text in the lower section of the page.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27920

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>George Joseph Flaccavento</b>				2. Date of Death Month Day Year <b>September 3, 2000</b>				3. Time of Death <b>4:00 PM</b>		
	4a. Facility Name (If not Institution, give street and number) <b>1-G Winesap Court</b>				4b. City, Town, or Location of Death <b>Catonsville</b>				4c. County of Death <b>Baltimore</b>		
Funeral Director	5. Social Security Number <b>104-16-1814</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>83</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>11-20-1916</b>		9. Birthplace (State or Foreign Country) <b>New York</b>		
	Usual Residence of Decedent				10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Catonsville</b>		
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number <b>1-G Winesap Court</b>				10f. Zip Code <b>21228</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>WW II</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>12 Years</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Appeals Examiner</b>				16b. Kind of Business/Industry <b>Department of Health Education &amp; Welfare</b>			
17. Father's Name (First, Middle, Last) <b>Rosario Flaccavento</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Francesca Lorifice</b>							
19a. Informant's Name/Relationship (Type, Print) <b>Anthony J. Flaccavento (Son)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>18157 Wyndale Road Abingdon, Virginia 24210</b>							
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Chesapeake Crematory</b>				20c. Date <b>09 07</b>		20d. Location - City or Town, State <b>Beltsville, Maryland</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Sterling-Ashton-Schwab Funeral Home, Inc.</b> <b>736 Edmondson Ave. Catonsville, MD 21228</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				a. <u>Cancer - Adenocarcinoma</u> Due to (or as a consequence of):							
				b. <u>Arteriosclerotic disease</u> Due to (or as a consequence of):							
				c. _____ Due to (or as a consequence of):							
				d. _____ Due to (or as a consequence of):							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 				29c. License number <b>042880</b>		29d. Date signed (Month, Day, Year) <b>9/06/00</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Thomas Smyth 8322 Bellona Avenue, Baltimore, Md.</b>											
31. Date filed (Month, Day, Year) <b>SEP 06 2000</b>				32. Registrar's Signature 							

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene 00 27921

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ANTHONY RICHARD FIOA, JR</b>						2. Date of Death Month Day Year <b>SEPTEMBER 3, 2000</b>		3. Time of Death <b>4:37 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>GILCHRIST CENTER</b>						4b. City, Town, or Location of Death <b>TOWSON</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>219-56-5867</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>44</b>		8. Date of Birth (Month, Day, Year) <b>JULY 5, 1956</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>MARYLAND</b>		10b. County <b>HARFORD</b>		10c. City, Town or Location <b>ABINGDON</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>2917 Ruskin Court</b>				10f. Zip Code <b>21009</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12YRS.</b> College (1-4or 5+) <b>2YRS.</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>CARPENTER</b>			16b. Kind of Business/Industry <b>TAYLOR MAOR CONSTRUCTION Co.</b>		
	17. Father's Name (First, Middle, Last) <b>ANTHONY RICHARD FIOA, SR.</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>DOLORES FLORENCE CAMPANELLA</b>				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>JOYCE A. FIOA</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2917 Ruskin Court ABINGDON, MARYLAND 21009</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GARDEN OF FAITH</b>		Date <b>SEPT. 8 2000</b>		20c. Location - City or Town, State <b>ROEDALE, MARYLAND</b>			
	21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>EVANS CHAPEL OF MEMORIES 8800 HARFORD ROAD PARKVILLE, MARYLAND 21234</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>colo-rectal cancer</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
Medical Certification: To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No									
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>									
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)										
28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <b>Dr. Anthony Riley, MD</b>					29c. License number <b>D25205</b>		29d. Date signed (Month, Day, Year) <b>September 4, 2000</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>W.A. Riley GPMC 6701 N. Charles St. Balto. md 2120x</b>										
31. Date filed (Month, Day, Year) <b>SEP 06 2000</b>		32. Registrar's Signature 								

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene 00 27922

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Earl Folks</b>				2. Date of Death Month <b>August</b> Day <b>30</b> Year <b>2000</b>		3. Time of Death <b>3:30am</b>	
	4a. Facility Name (If not institution, give street and number) <b>Genesis Elder Care</b>				4b. City, Town, or Location of Death <b>Randallstown</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>216-16-2550</b>		6. Sex <b>XX</b> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>76</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>06 01 24</b>	
	9. Birthplace (State or Foreign Country) <b>M.D.</b>		10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Randallstown</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>3812 Cherry Brook Road</b>		10f. Zip Code <b>21133</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Laborer</b>		16b. Kind of Business/Industry <b>McCormick Spice Co.</b>		17. Father's Name (First, Middle, Last) <b>Charles Folks</b>		
18. Mother's Name (First, Middle, Maiden Sumame) <b>Josephine Ruff</b>		19a. Informant's Name/Relationship (Type, Print) <b>Victor Folks-Son</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3812 Cherry Brook Rd, Randallstown Md 21133</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		
20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Garrison Forest Vet.</b>		20c. Location - City or Town, State <b>9/6/2000 Owings Mills, Md</b>		21. Signature of Funeral Service Licensee <b>John March</b>		22. Name and Address of Facility <b>March F/H West 4300 Wabash Ave, Baltimore Md 21215</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>a. Arteriosclerosis</b>		Due to (or as a consequence of):		Approximate Interval Between Onset and Death <b>10 years</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
23c. Immediately list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b>		Due to (or as a consequence of):		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
23d. Due to (or as a consequence of):		Due to (or as a consequence of):		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		
29b. Signature and title of certifier <b>Jerome H. Ginsberg, M.D.</b>		29c. License number <b>D0020964</b>		29d. Date signed (Month, Day, Year) <b>09-05-00</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Jerome H. Ginsberg, M.D. 8630 Liberty Plaza Mall Randallstown, MD 21133</b>		
31. Date filed (Month, Day, Year) <b>SEP 06 2000</b>		32. Registrar's Signature <b>Sparks</b>		33. State Registrar <b>SEP 06 2000</b>		34. DHMH 16 Rev 6/95		

ORIGINAL

Page 1

1/1/1970

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27923

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CHARLES DAVID FISCHER

2. Date of Death

Month Day Year  
SEPTEMBER 3, 2000

3. Time of Death

3:30 P.M.

4a. Facility Name (If not institution, give street and number)

STELLA MARIS HOSPICE

4b. City, Town, or Location of Death

TIMONIUM

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

219-50-0805

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

53

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
2/13/1947

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

PRINCE GEORGE

10c. City, Town or Location

UPPER MARLBORO

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4379 RYON ROAD

10f. Zip Code

20772

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ NoIf Yes, Give  
Year or Dates: VIETNAM13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12TH GRADE

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

SURVEYOR/COMPUTER TECH.

16b. Kind of Business/Industry

ENGINEERING

17. Father's Name (First, Middle, Last)

JOHN GEORGE FISCHER

18. Mother's Name (First, Middle, Maiden Surname)

GEORGIA SPEER

19a. Informant's Name/Relationship (Type, Print)

JOHN FISCHER

BROTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1715 REDWOOD AVENUE BALTIMORE, MD 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

DULANEY VALLEY MEM. GAR. 9/8/00

Date

20c. Location - City or Town, State

COCKEYSVILLE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

THE JOHNSON FUNERAL HOME, P.A.

8521 LOCH RAVEN BLVD. TOWSON, MD 21286

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Malignant Melanoma

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☒ Other (Specify)

Hospice

27. Manner of Death

1 ☒ Natural  
2 ☐ Accident  
3 ☐ Suicide  
4 ☐ Homicide5 ☐ Pending  
investigation  
6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and Title of certifier

29c. License number

D43725

29d. Date signed (Month, Day, Year)

9/5/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Tariq Mahmood, 2300 Dulane Valley Road, Timonium, MD 21093

31. Date filed (Month, Day, Year)

SEP 06 2000

32. Registrar's Signature

State  
RegistrarSeptember 3, 2000 3:30 p.m.  
Baltimore, Maryland 21215-0020permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Charles Fischer  
Division of Vital Records, P.O. Box 68760,To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10/1

AN



JOHAUD FERGUSON

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State of Maryland / Department of Health and Mental Hygiene

00 27924

## Certificate of Death

Reg. No.

amend item 23a, 27 per me G789 11/6/00 vt  
Amended items 4, 9, 10b per FD G787 9-6-00 WJJ

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JAHAUD JEVON ZYKIR FERGUSON</b>		2. Date of Death Month Day Year <b>JULY 21 2000</b>		3. Time of Death <b>8:30 AM</b>
	4a. Facility Name (If not Institution, give street and number) <b>FREDERICK MEMORIAL HOSPITAL</b>		4b. City, Town, or Location of Death <b>FREDERICK</b>		4c. County of Death <b>FREDERICK</b>
Funeral Director	5. Social Security Number <b>214-57-8351</b>	6. Sex <b>MALE</b> <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. <b>51</b>	8. Date of Birth (Month, Day, Year) <b>01-30-00</b>	
	10a. State <b>MD.</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>4104 OLD MILFORD MILL RD. PIKESVILLE, MD</b>
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>4104 OLD MILFORD MILL RD.</b>		10f. Zip Code <b>21208</b>	
10g. Citizen of What Country? <b>U.S.A.</b>		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>BLACK</b>		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>NA</b> College (1-4 or 5+) <b>College</b>	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry		17. Father's Name (First, Middle, Last) <b>KEYON FERGUSON</b>	
18. Mother's Name (First, Middle, Maiden Surname) <b>MONICA RANDOLPH</b>		19a. Informant's Name/Relationship (Type, Print) <b>MONICA RANDOLPH (MOTHER)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4104 OLD MILFORD MILL RD. PIKESVILLE, MD 21208</b>	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>BARTONSVILLE CEM.</b>		20c. Location - City or Town, State <b>7-26-00 FREDERICK, MD.</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>GARY L. ROLLINS F.H. 110 SOUTH STREET, FREDERICK, MD. 21701</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>PREMATURITY WITH COMPLICATIONS</b> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>M</b>		28b. Time of Injury <b>1</b> Yes <input type="checkbox"/> No	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>O.C.M.E.</b>	
29d. Date signed (Month, Day, Year) <b>JULY 22, 2000</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>THEODOR M. KORY 111 Penn Street, Baltimore, Maryland 21201</b>			
31. Date filed (Month, Day, Year) <b>SEP 06 2000</b>		32. Registrar's Signature 			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
ExaminerDivision of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





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State of Maryland / Department of Health and Mental Hygiene

00 27925

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Linda Fowler</i>		2. Date of Death Month <i>8</i> Day <i>29</i> Year <i>00</i>		3. Time of Death <i>4 55p</i>
	4a. Facility Name (If not institution, give street and number) <i>Bon Secours Hospital</i>		4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>N/A</i>
Funeral Director	5. Social Security Number <i>237 68 7922</i>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>54</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth Month, Day, Year <i>Nov. 7, 1945</i>		9. Birthplace (State or Foreign Country) <i>Maryland</i>		
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State <i>Maryland</i>		10b. County <i>N/A</i>
	10c. City, Town or Location <i>Baltimore</i>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <i>1625 DRUID HILL AVE</i>		10f. Zip Code <i>21217</i>		
	10g. Citizen of What Country? <i>USA</i>				
To Be Completed by Physician/Medical Examiner	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>9th grade</i> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Custodian</i>		16b. Kind of Business/Industry <i>Fallon Building</i>
	17. Father's Name (First, Middle, Last) <i>George Boykin</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Jennine McNaire</i>		
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <i>Linda Martin / Daughter</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>21213</i> <i>1105 N. Lakewood Ave Baltimore, Maryland</i>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Ver Hall Memorial Garden</i>		20c. Location - City or Town, State <i>Dundalk, Maryland</i>
	21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <i>CHATHAM - HARRIS Funeral Home</i> <i>5240 REISTERSTOWN ROAD</i> <i>BALTIMORE, MD 21211</i>		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  <i>1. ANDOXIC encephalopathy and</i> <i>2. Cardio pulmonary arrest</i> <i>3. Aspiration pneumonia</i> <i>4. Terminal AIDS</i>		Approximate Interval Between Onset and Death <i>2d</i> <i>2d</i> <i>2d</i> <i>1 yr.</i>		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <i>D 29769</i>	29d. Date signed (Month, Day, Year) <i>8/31/00</i>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Marcelino D. Alvarez</i> <i>516 W. Rolling Rd Baltimore</i>					
31. Date filed (Month, Day, Year) <i>SEP 6 2000</i>		32. Registrar's Signature <i>[Signature]</i>			

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

00 27926

Amended item# 20c per FH G787 9-6-00 WJJ

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>William Grube</b>		2. Date of Death Month <b>SEPTEMBER</b> Day <b>1</b> Year <b>2000</b>		3. Time of Death <b>2326 hrs</b>							
	4a. Facility Name (If not institution, give street and number) <b>SINAI HOSPITAL OF BALTIMORE</b>		4b. City, Town, or Location of Death <b>BALTIMORE CITY</b>		4c. County of Death							
Funeral Director	5. Social Security Number <b>278-14-5081</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>82</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.							
	8. Date of Birth (Month, Day, Year) <b>May 24, 1918</b>		9. Birthplace (State or Foreign Country) <b>OH</b>									
Usual Residence of Decedent												
10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Timonium</b>								
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No												
10e. Street and Number <b>405 Plum Bridge Court #203</b>			10f. Zip Code <b>21093</b>		10g. Citizen of What Country? <b>USA</b>							
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:								
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>												
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>5+</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Physicist</b>		16b. Kind of Business/Industry <b>Automotive Research</b>								
17. Father's Name (First, Middle, Last) <b>John Henry Grube</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Pearl Nida</b>									
19a. Informant's Name/Relationship (Type, Print) <b>Betty Grube Wife</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>405 Plum Bridge Court #203 Timonium, MD 21093</b>									
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Roseland Park Cemetery</b>		20c. Location - City or Town, State <b>Berkley, MI</b>								
20d. Date <b>09/08</b>												
21. Signature of Funeral Service Licensee <b>Robert C. Lucas</b>			22. Name and Address of Facility <b>Sterling Ashton Schwab Funeral Home, Inc. 736 Edmondson Ave. Baltimore, MD 21228</b>									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
<table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a. <b>UNCAL HERNIATION</b></td> <td rowspan="4">           Due to (or as a consequence of):   <b>SUBDURAL HEMATOMA</b>             Due to (or as a consequence of):             Due to (or as a consequence of):             Due to (or as a consequence of):         </td> <td rowspan="4">           Approximate Interval Between Onset and Death   <b>3 DAYS</b> </td> </tr> <tr><td>b.</td></tr> <tr><td>c.</td></tr> <tr><td>d.</td></tr> </table>						Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. <b>UNCAL HERNIATION</b>	Due to (or as a consequence of):  <b>SUBDURAL HEMATOMA</b>  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	Approximate Interval Between Onset and Death  <b>3 DAYS</b>	b.	c.	d.
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. <b>UNCAL HERNIATION</b>	Due to (or as a consequence of):  <b>SUBDURAL HEMATOMA</b>  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	Approximate Interval Between Onset and Death  <b>3 DAYS</b>									
	b.											
	c.											
	d.											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown												
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No												
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No												
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>AUG 30 00</b>		28b. Time of Injury <b>1700H M</b>								
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>FELL FROM A STANDING POSITION</b>										
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>PARKING LOT IN FRONT OF HOUSE</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>405 PLUM BRIDGE COURT, VILAS</b>										
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
29b. Signature and title of certifier <b>BENNY TAN MD</b>		29c. License number <b>RES 000</b>		29d. Date signed (Month, Day, Year) <b>SEPTEMBER 2 2000</b>								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>BENNY TAN MD SINAI HOSPITAL BALTIMORE</b>												
31. Date filed (Month, Day, Year) <b>SEP 06 2000</b>		32. Registrar's Signature <b>[Signature]</b>										

ORIGINAL



00 27927

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

MISSOURI BOTANICAL GARDEN

*Handwritten text, possibly a signature or name.*



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27928

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>GARY E GREVEY</b>		2. Date of Death Month <b>SEPT.</b> Day <b>5</b> Year <b>2000</b>		3. Time of Death <b>8:00am</b>
	4a. Facility Name (If not institution, give street and number) <b>100 Lariet Road</b>		4b. City, Town, or Location of Death <b>Middle River</b>		4c. County of Death <b>Baltimore</b>
Funeral Director	5. Social Security Number <b>220-44-6443</b>	6. Sex <b>20 M</b> 20 F	7. Age (In yrs. last birthday) <b>49</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>July 5 1951</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
Usual Residence of Decedent					
10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Middle River</b>	
10d. Inside City Limits <b>1</b> Yes <b>2</b> No					
10e. Street and Number <b>100 Lariet Road</b>			10f. Zip Code <b>21220</b>		10g. Citizen of What Country? <b>USA</b>
11. Marital Status <b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> Yes <b>2</b> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> Yes <b>2</b> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Security Officer</b>		16b. Kind of Business/Industry <b>Pinkerton</b>
17. Father's Name (First, Middle, Last) <b>Eugene B. Grevey</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Elizabeth Ann Gransee</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Barbara A Grevey / wife</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>100 Lariet Road Baltimore Md. 21220</b>		
20a. Method of Disposition <b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory Inc. 9/8/2000</b>		20c. Location - City or Town, State <b>Baltimore MD</b>	
21. Signature of Funeral Service Licensee <b>R. Terry Connelly</b>		22. Name and Address of Facility <b>Connelly Funeral Home of Essex 300 MACE AVE. Baltimore MD. 21220</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Brain Cancer</b> Due to (or as a consequence of): <b>b. Metastatic prostate CA</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? <b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown
					24a. Was an autopsy performed? <b>1</b> Yes <b>2</b> No
					24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> Yes <b>2</b> No
25. Was case referred to medical examiner? <b>1</b> Yes <b>2</b> No		26. Place of Death (Check only one) Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify)			
27. Manner of Death <b>1</b> Natural <b>5</b> Pending investigation <b>2</b> Accident <b>6</b> Could not be determined <b>3</b> Suicide <b>4</b> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
		28c. Injury at Work? <b>1</b> Yes <b>2</b> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <b>2</b> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier <b>Michael M. Sparks MD</b>		29c. License number <b>051883</b>		29d. Date signed (Month, Day, Year) <b>9/6/00</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Michael M. Sparks MD 1576 Merritt Blvd, Baltimore, MD 21224</b>					
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 06 2000</b>		32. Registrar's Signature <b>Michael M. Sparks</b>		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27929

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EMMA J GRIMM				2. Date of Death Month Day Year SEPT. 4 2000		3. Time of Death 11:58pm	
	4a. Facility Name (If not institution, give street and number) 601 Sophwith Drive				4b. City, Town, or Location of Death Middle River		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 280-20-3903		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 77 Yrs.		8. Date of Birth Month Day Year Feb. 4 1923	
	10a. State MD		10b. County Baltimore		10c. City, Town or Location Middle river		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
Usual Residence of Decedent								
10e. Street and Number 601 Sophwith Drive Apt. H				10f. Zip Code 21220		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Machinest		16b. Kind of Business/Industry Ray Machines		
17. Father's Name (First, Middle, Last) Matthew Roll				18. Mother's Name (First, Middle, Maiden Surname) Willie Schaefer				
19a. Informant's Name/Relationship (Type, Print) Carol Harker / daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 601 Sophwith Drive Baltimore Md. 21220				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory Inc, 9/7/2000		20c. Location - City or Town, State Baltimore Md.		
21. Signature of Funeral Service Licensee R. Terry Connelly				22. Name and Address of Facility Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cancer lung Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death 11 mths								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of injury (Month, Day Year)		28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier MD				29c. License number D18487		29d. Date signed (Month, Day, Year) 9/5/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MYO THANT 6830 HOSPITAL DRIVE, BALTO, MD 21237								
31. Date filed (Month, Day, Year) SEP 06 2000				32. Registrar's Signature Benjamin A Sparks				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27930

AMENDED ITEM #26 PER MD G787 9/6/00 AH

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Dorothy Lee Green				2. Date of Death Month Day Year 8 28 2000		3. Time of Death 9 30 a.m.	
	4a. Facility Name (If not institution, give street and number) 809 Milford Mill Road				4b. City, Town, or Location of Death Pikesville		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 228-29-4117	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 73 Yrs.	8. Date of Birth (Month, Day, Year) 5-20-1927	9. Birthplace (State or Foreign Country) Md			
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Md	10b. County N/A	10c. City, Town or Location Baltimore		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	10e. Street and Number 3321 Brighton Street			10f. Zip Code 21216		10g. Citizen of What Country? U S A		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) L P N		16b. Kind of Business/Industry Nursing			
	17. Father's Name (First, Middle, Last) Todd Hobbs				18. Mother's Name (First, Middle, Maiden Surname) Inez Brooks			
To Be Completed by Physician/Medical Examiner	19e. Informant's Name/Relationship (Type, Print) Demetria Mone Knight-Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3114 St Lukes Lane Baltimore, Md 21207				
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) King Memorial Park		20c. Location - City or Town, State 9-1-00 Randallstown, Md			
	21. Signature of Funeral Service Licensee Jerome A. Thompson			22. Name and Address of Facility March F/H West 4300 Wabash Avenue Baltimore, Md 21215				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pancreatic Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
State Registrar	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence - 6 <input type="checkbox"/> Other (Specify) DAUGHTER HOUSE			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
			28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier David A. Rosenberg				29c. License number D40854		29d. Date signed (Month, Day, Year) 8/29/2000	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) David Rosenberg 301 St Paul Pl Baltimore 21202								
31. Date filed (Month, Day, Year) SEP 06 2000				32. Registrar's Signature Benjamin B Sparks				

ORIGINAL







Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Karen Elizabeth Grimes</b>				2. Date of Death Month Day Year <b>August 31, 2000</b>				3. Time of Death <b>10:00 P.M.</b>		
	4a. Facility Name (If not institution, give street and number) <b>2725 Beckon Drive</b>				4b. City, Town, or Location of Death <b>Abingdon</b>				4c. County of Death <b>Harford</b>		
Funeral Director	5. Social Security Number <b>217-56-9031</b>		8. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>37</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		
	6. Date of Birth (Month, Day, Year) <b>June 5, 1963</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>MD.</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Abingdon</b>		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>2725 Beckon Drive</b>		10f. Zip Code <b>21040</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Secretary</b>	
16b. Kind of Business/Industry <b>DM Distribution</b>		17. Father's Name (First, Middle, Last) <b>Norman R. Grimes, Sr.</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Virginia L. Haddaway</b>		19a. Informant's Name/Relationship (Type, Print) <b>Norman R. Grimes, Sr.</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1648 Wall Dr. Pasadena, MD. 21122</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Greenmount Cedar Hill Cemetery</b>		Date <b>9-3-00</b>		20c. Location - City or Town, State <b>Balto., MD.</b>		21. Signature of Funeral Service Licensee <b>KEVIN E. ECKER</b>		22. Name and Address of Facility <b>McCully-Polyniak Funeral Home P.A. 3204 Mountain Rd. Pasadena, MD. 21122</b>	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Hanging</b>  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Due to (or as a consequence of):</b>  <b>Due to (or as a consequence of):</b>  <b>Due to (or as a consequence of):</b>		Approximate Interval Between Onset and Death		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <b>Inspection</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>at scene</b>		27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>Found: 08-31-2000</b>		28b. Time of Injury <b>Found: 9:51 P</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>Subject hanged self.</b>		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Home</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>2725 Beckon Drive Abingdon, Maryland</b>		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
29b. Signature and title of certifier <b>[Signature]</b>		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>September 01, 2000</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>John E. Smialek, M.D. 111 Penn Street, Baltimore, Maryland 21201</b>		31. Date filed (Month, Day, Year) <b>SEP 06 2000</b>		32. Registrar's Signature <b>[Signature]</b>	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27932

Amended Item#12perFH,23b perPHYG787 9/28/2000 EW

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Donald Griffith</u>		2. Date of Death Month <u>September</u> Day <u>2</u> Year <u>2000</u>		3. Time of Death <u>1455</u>
	4a. Facility Name (If not institution, give street and number) <u>The Johns Hopkins Hospital</u>		4b. City, Town, or Location of Death <u>Baltimore City</u>		4c. County of Death <u>N/A</u>
Funeral Director	5. Social Security Number <u>216-34-5903</u>	6. Sex <u>SEX M</u> <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <u>61</u> Yrs.	If Under 1 Year Months <u>  </u> Days <u>  </u>	If Under 24 Hrs. Hours <u>  </u> Min. <u>  </u>
	8. Date of Birth (Month, Day, Year) <u>March 14, 1939</u>		9. Birthplace (State or Foreign Country) <u>Maryland</u>		
Usual Residence of Decedent					
10a. State <u>Maryland</u>		10b. County <u>Baltimore</u>		10c. City, Town or Location <u>Dundalk</u>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <u>1903 Armco Way</u>		10f. Zip Code <u>21222</u>		10g. Citizen of What Country? <u>United States</u>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <u>1961-68</u>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <u>  </u>	
14. Race - American Indian, Black, White, etc. Specify: <u>White</u>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12 Years</u> College (1-4 or 5+) <u>  </u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Truck Driver</u>		16b. Kind of Business/Industry <u>Trucking Industry</u>	
17. Father's Name (First, Middle, Last) <u>Charles Griffith</u>		18. Mother's Name (First, Middle, Maiden Surname) <u>Lillian M. Knight</u>			
19a. Informant's Name/Relationship (Type, Print) (Wife) <u>Mrs. Sharon A. Griffith</u>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1903 Armco Way Dundalk, Maryland 21222</u>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <u>  </u>		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Holly Hill Mem. Gdns. 9/6/2000</u>		20c. Location - City or Town, State <u>Middle River, MD</u>	
21. Signature of Funeral Service Licensee <u>[Signature]</u>		22. Name and Address of Facility <u>Duda-Ruck Funeral Home of Dundalk, Inc.</u> <u>7922 Wise Ave. Dundalk, Maryland 21222</u>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <u>Multiple Organ Failure</u> Due to (or as a consequence of): <u>Aortic Dissection</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <u>  </u> <u>  </u> <u>  </u> <u>  </u>		Approximate Interval Between Onset and Death <u>4 hours</u> <u>10 hours</u>			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>  </u> <u>  </u> <u>  </u>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <u>  </u>			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) <u>  </u>		28b. Time of Injury <u>  </u> M <u>  </u>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred <u>  </u>		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <u>  </u>	
28f. Location (Street and Number or Rural Route Number, City or Town, State) <u>  </u>					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <u>[Signature]</u>		29c. License number <u>Res 000</u>		29d. Date signed (Month, Day, Year) <u>September 2, 2000</u>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Albert Ong MD 600 North Wolfe Street, Baltimore MD 21205</u>					
31. Date filed (Month, Day, Year) <u>SEP 06 2000</u>		32. Registrar's Signature <u>[Signature]</u>			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27933

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Florence Emma Henn				2. Date of Death Month Day Year August 31 2000		3. Time of Death 12:50 pm	
	4a. Facility Name (If not institution, give street and number) Genesis Eldercare-Catonsville Commons				4b. City, Town, or Location of Death Catonsville		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 216-01-9715		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 93		8. Date of Birth (Month, Day, Year) 06/16/1907	
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County Howard		10c. City, Town or Location Ellicott City	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 9317 Ramsey Drive		10f. Zip Code 21042		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sales		16b. Kind of Business/Industry Retail			
	17. Father's Name (First, Middle, Last) Frank Holtzman				18. Mother's Name (First, Middle, Maiden Surname) Lucille Hildasheim			
	19a. Informant's Name/Relationship (Type, Print) Patricia McNulty Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9317 Ramsey Drive, Ellicott City MD 21042			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) New Cathedral Cemetery		20c. Location - City or Town, State 9/2/00 Baltimore, Maryland			
	21. Signature of Funeral Service Licensee Robert J. Adams		22. Name and Address of Facility Sterling-Ashton-Schwab Funeral Home, Inc. 736 Edmondson Avenue Catonsville, MD 21228					
	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CHF Due to (or as a consequence of): ASCVD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
State Registrar	29b. Signature and title of certifier B. P. N. K. To KAKHIA		29c. License number D36942		29d. Date signed (Month, Day, Year) 9/1/2000			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) B. P. N. K. To KAKHIA - 1009 FREDIE K RD. 21228							
31. Date filed (Month, Day, Year) SEP 06 2000		32. Registrar's Signature B. P. N. K. To KAKHIA						





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27934

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Lillian E. Heil</u>		2. Date of Death Month <u>September</u> Day <u>12</u> Year <u>2000</u>		3. Time of Death <u>8:40 AM</u>
	4a. Facility Name (If not institution, give street and number) <u>FRANKLIN SQUARE HOSPITAL</u>		4b. City, Town, or Location of Death <u>ROSBAL</u>		4c. County of Death <u>BALTIMORE</u>
Funeral Director	5. Social Security Number <u>216 07 8746</u>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <u>79</u> Yrs.	If Under 1 Year Months <u>  </u> Days <u>  </u>	If Under 24 Hrs. Hours <u>  </u> Min. <u>  </u>
	8. Date of Birth (Month, Day, Year) <u>JAN 4, 1921</u>		9. Birthplace (State or Foreign Country) <u>MARYLAND</u>		
Usual Residence of Decedent					
10a. State <u>MARYLAND</u>		10b. County <u>BALTIMORE</u>		10c. City, Town or Location <u>BALTIMORE</u>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <u>1612 ROSZWICK AVE</u>		10f. Zip Code <u>21237</u>		10g. Citizen of What Country? <u>U.S.A.</u>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <u>WHITE</u>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>8 YRS.</u> College (1-4 or 5+) <u>  </u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>HOMEMAKER</u>		16b. Kind of Business/Industry <u>AT HOME</u>	
17. Father's Name (First, Middle, Last) <u>GEORGE BOSS</u>		18. Mother's Name (First, Middle, Maiden Surname) <u>LILLIAN HUGHES</u>			
19a. Informant's Name/Relationship (Type, Print) <u>JOHN E. HEIL</u>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1612 ROSZWICK AVE. BALTIMORE MARYLAND 21237</u>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>EVANS FUNERAL CHAPEL - SAT. 4, 2000, 821 AIR, P.A.</u>		20c. Location - City or Town, State <u>FOREST HILL MARYLAND</u>	
21. Signature of Funeral Service licensee <u>[Signature]</u>		22. Name and Address of Facility <u>EVANS CHAPEL OF MEMORIES 21234 8800 HARFORD ROAD PARKVILLE MARYLAND</u>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		a. <u>Myelodysplastic Syndrome</u> Due to (or as a consequence of):			Approximate Interval Between Onset and Death <u>1 YR</u>
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. <u>Congestive heart failure</u> Due to (or as a consequence of):			<u>1 YR</u>
c. <u>  </u> Due to (or as a consequence of):					
d. <u>  </u> Due to (or as a consequence of):					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Non Hodgkins Lymphoma</u>					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M <u>  </u>	
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <u>[Signature]</u>		29c. License number <u>D45530</u>		29d. Date signed (Month, Day, Year) <u>SEPTEMBER 2, 2000</u>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>DR. SANKARI SIVASAILAM 6830 HOSPITAL DRIVE, MD-21237</u>					
31. Date filed (Month, Day, Year) <u>SEP 06 2000</u>		32. Registrar's Signature <u>[Signature]</u>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27935

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ROBERT LEE HOWARD				2. Date of Death Month Day Year SEPTEMBER 4, 2000		3. Time of Death 5:50 AM		
	4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 215-28-5950		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 68 Yrs.		8. Date of Birth (Month, Day, Year) Jun 19, 1932		
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County Baltimore		10c. City, Town or Location Parkville		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 2700 Glendale Rd.		10f. Zip Code 21234		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Meat inspector		16b. Kind of Business/Industry Federal Government		17. Father's Name (First, Middle, Last) Luther Howard		18. Mother's Name (First, Middle, Maiden Surname) Mary Ward		19a. Informant's Name/Relationship (Type, Print) Gloria Z. Howard	
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2700 Glendale Rd., Parkville, MD 21234		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery		Date Sep 8 2000		20c. Location - City or Town, State Parkville, MD	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Dippel Funeral Home 7110 Belair Rd. Baltimore, MD		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  PNEUMONIA  Due to (or as a consequence of): PROGRESSIVE INTERSTITIAL LUNG DISEASE  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):		Approximate Interval Between Onset and Death		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	
28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D41410		29d. Date signed (Month, Day, Year) September 4th, 2000		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOGINDER P. MEHTA M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204	
31. Date filed (Month, Day, Year) SEP 06 2000		32. Registrar's Signature 		State Registrar		33. Date of Death SEP 06 2000		34. Registrar's Signature 	

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27936

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Brandon Christopher Hamlet				2. Date of Death Month Day Year September 1, 2000		3. Time of Death 9:15 PM	
	4a. Facility Name (If not institution, give street and number) 8009A Burk Ct.				4b. City, Town, or Location of Death Ft. Meade		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 224-75-8941		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 4 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 20, 1995	
	9. Birthplace (State or Foreign Country) Virginia		10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Ft. Meade	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 8009A Burk Ct.		10f. Zip Code 20755		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) N/A		16b. Kind of Business/Industry N/A		17. Father's Name (First, Middle, Last) Christopher Wayne Hamlet	
	18. Mother's Name (First, Middle, Maiden Surname) Debra Louise Clark		19e. Informant's Name/Relationship (Type, Print) Christopher W. Hamlet, father		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8009A Burk Ct. Ft. Meade, MD. 20755		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	
Physician /Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory		20c. Location - City or Town, State Catonsville, MD		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD. 21227	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Intractable Seizures</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death 1 day		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
Medical Certification: To Be Completed by Physician/Medical Examiner	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day, Year) M		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 	
	29c. License number 34-00-7388-P		29d. Date signed (Month, Day, Year) September 2, 2000		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Martha T.K. Proen WRAMC Department of Pediatrics Washington, D.C.		31. Date filed (Month, Day, Year) SEP 06 2000	
State Registrar	32. Registrar's Signature 		33. Date of Death SEP 06 2000		34. Date of Death SEP 06 2000		35. Date of Death SEP 06 2000	

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27937

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CHARLOTTE MARIE HAINES

2. Date of Death

AUGUST 30, 2000 9:42 AM

Day Year

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

211-263642

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

77

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

MARCH 8, 1923

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

BALTIMORE

10c. City, Town or Location

LARNY

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

3108 SUMMIT AVE.

10f. Zip Code

21234

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8YRS.

College (1-4or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

AT HOME

17. Father's Name (First, Middle, Last)

GUY LEISTER

18. Mother's Name (First, Middle, Maiden Surname)

HELEN SUE

19a. Informant's Name/Relationship (Type, Print)

SARINISTIA M. FREEDY

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3108 SUMMIT AVE LARNY, MARYLAND 21234

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

EVERGREEN MEM. PARK

Date

SEPT. 2

20c. Location - City or Town, State

2000 FINKSBURG, MARYLAND

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

EVANS CHAPEL OF MEMORIES 21234

8800 HARFORD ROAD PARKVILLE, MARYLAND

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

RESPIRATORY FAILURE

Approximate Interval Between Onset and Death

10 HOURS

a. Due to (or as a consequence of):

SEPSIS, UNKNOWN SOURCE

5 DAYS

b. Due to (or as a consequence of):

RIGHT HEART FAILURE

MONTHS

c. Due to (or as a consequence of):

CORONARY ARTERY DISEASE- ANGINA

6 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

STATUS POST STENT (8/24)

LEFT ANTERIOR DESCENDING FOR CORONARY ARTERY DISEASE

? CANCER (L) PLEURAL SPACE - W/U SUGGESTIVE BUT NOT

CONCLUSIVE

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Pending Investigation☐ Accident☐ Suicide☐ Homicide☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician

29b. Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. Signature and title of certifier

[Signature]

29d. License number

D35453

29e. Date signed (Month, Day, Year)

8/30/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LINDA BARR M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

SEP 06 2000

32. Registrar's Signature

[Signature]

State  
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-358-2000.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-358-2000.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27938

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Margaret Hughes

2. Date of Death  
Month Day Year  
8 31 2000  
3. Time of Death  
5:35 AM

4a. Facility Name (If not institution, give street and number)

Oak Crest Village

4b. City, Town, or Location of Death

Parkville

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

212-10-6811

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

94

8. Date of Birth (Month, Day, Year)

8-21-1906

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD.

10b. County

Baltimore

10c. City, Town or Location

Parkville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8800 Walther Boulevard

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Koester's Bakery

17. Father's Name (First, Middle, Last)

Walter G. Hughes

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Ann Bradley

19a. Informant's Name/Relationship (Type, Print)

H. Emslie Parks

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

102 W. Pennsylvania, Suite # 600 Towson, Maryland 21204

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lorraine Park Cemetery

Date

9/05/2000

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

Witzke Funeral Home of Catonsville  
1630 Edmondson Avenue, Catonsville, MD. 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Alzheimer's Disease  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.   
Due to (or as a consequence of):

c.   
Due to (or as a consequence of):

d.   
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Multiple myeloma, Osteoporosis,  
Hip fracture.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*[Signature]*

29c. License number

D34941

29d. Date signed (Month, Day, Year)

8-31-2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Susan G. Weiner MD 8800 Walther Blvd Parkville, Md 21234

31. Date filed (Month, Day, Year)

32. Registrar's Signature

SEP 06 2000

*[Signature]*

State  
Registrar

5:35 AM  
Baltimore, Maryland 21215-0020  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

5:35 AM  
August 31, 2000  
Margaret Hughes  
Division of Vital Records, P.O. Box 68760, R

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27939

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Edward Heinz II</b>				2. Date of Death Month <b>Sept</b> Day <b>1</b> Year <b>2000</b>				3. Time of Death <b>4:15pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>Gilchrist Hospice Center</b>				4b. City, Town, or Location of Death <b>Towson</b>				4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>217-22-3253</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (in yrs. last birthday) <b>77</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Aug 19 1923</b>		9. Birthplace (State or Foreign Country) <b>MD.</b>	
	Usual Residence of Decedent									
10a. State <b>MD.</b>		10b. County		10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>100 Harborview Drive, #408</b>				10f. Zip Code <b>21230</b>				10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>owner/operator</b>				16b. Kind of Business/Industry <b>H. T. Heinz Meat Packing</b>		
17. Father's Name (First, Middle, Last) <b>Henry T. Heinz</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Katharine J. Schaaß</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Steve Brennan, Personal Rep.</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1 Glenbrook Drive, Phoenix, Md. 21131</b>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Loudon Park Cemetery</b>		Date <b>9/5/00</b>		20c. Location - City or Town, State <b>Baltimore, Md.</b>				
21. Signature of Funeral Service Licensee <b>► Glenda L Lemmer</b>				22. Name and Address of Facility <b>Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Ave., Catonsville, Md. 21228</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Lung cancer</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d.</b>								Approximate Interval Between Onset and Death <b>7 months</b>		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
								24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>Hospice</b>								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <b>► Anthony J. ...</b>				29c. License number <b>D25205</b>		29d. Date signed (Month, Day, Year) <b>September 1, 2000</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>W.A.R. Tex. G.B.M.C. 6701 N. Charles St. Balto. Md 21208</b>										
31. Date filed (Month, Day, Year) <b>SEP 06 2000</b>				32. Registrar's Signature <b>Benjamin B Sparks</b>						

ORIGINAL






Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27940

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ROSE HALIKMAN</b>		2. Date of Death Month Day Year <b>SEPTEMBER 1, 2000</b>		3. Time of Death <b>2:35 PM</b>
	4a. Facility Name (If not institution, give street and number) <b>CHERRYWOOD NURSING HOME</b>		4b. City, Town, or Location of Death <b>REISTERSTOWN</b>		4c. County of Death <b>BALTIMORE</b>
Funeral Director	5. Social Security Number <b>213-52-5935</b>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>89</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth Month Day Year <b>SEPT 25 1910</b>		9. Birthplace (State or Foreign Country) <b>MD</b>		
Usual Residence of Decedent					
10a. State <b>MD</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>OWINGS MILLS</b>	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
10e. Street and Number <b>2403 VELVET VALLEY WAY</b>			10f. Zip Code <b>21117</b>		10g. Citizen of What Country? <b>USA</b>
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOMEMAKER</b>		16b. Kind of Business/Industry <b>OWN HOME</b>
17. Father's Name (First, Middle, Last) <b>LOUIS SCHAFF</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>KATIE DAVIS</b>		
19a. Informant's Name/Relationship (Type, Print) <b>DR. LOUIS HALIKMAN/SON</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2403 VELVET VALLEY WAY OWINGS MILLS, MD. 21117</b>		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>HEBREW FRIENDSHIP</b>		20c. Location - City or Town, State <b>9/3/00 BALTIMORE, MD.</b>	
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death) a. <b>pneumonia</b> Due to (or as a consequence of):					
b. Due to (or as a consequence of):					
c. Due to (or as a consequence of):					
d. Due to (or as a consequence of):					
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Conjunctive Heart Failure</b> <b>Stroke</b>					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number <b>027123</b>		29d. Date signed (Month, Day, Year) <b>9/1/00</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Julie Minkove 770 Main St Reisterstown, MD 21138</b>					
31. Date filed (Month, Day, Year) <b>SEP 06 2000</b>		32. Registrar's Signature 			

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 00 27941

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Ella R. Jackson</i>				2. Date of Death Month <i>08</i> Day <i>31</i> Year <i>2000</i>		3. Time of Death <i>11:15 AM</i>	
	4a. Facility Name (If not institution, give street and number) <i>St. Elizabeth Nursing Home</i>				4b. City, Town, or Location of Death <i>Balto.</i>		4c. County of Death <i>NA</i>	
Funeral Director	5. Social Security Number <i>212 08 2949</i>		6. Sex <i>1 M 2 F</i>	7. Age (In yrs. last birthday) <i>77</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>March 29 1923</i>	9. Birthplace (State or Foreign Country) <i>MD</i>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <i>MD</i>	10b. County <i>NA</i>	10c. City, Town or Location <i>Baltimore</i>			10d. Inside City Limits <i>1 Yes 2 No</i>		
	10e. Street and Number <i>3300 Benson Ave</i>			10f. Zip Code		10g. Citizen of What Country? <i>USA</i>		
	11. Marital Status <i>1 Never Married 2 Married 3 Widowed 4 Divorced</i>		12. Was Decedent Ever in U.S. Armed Forces? <i>1 Yes 2 No</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <i>1 Yes 2 No</i>		14. Race - American Indian, Black, White, etc. <i>African American</i>	
	15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12) 12th</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Personal Development</i>		16b. Kind of Business/Industry <i>Homes</i>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <i>John Jackson</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Hillian Jackson</i>			
	19a. Informant's Name/Relationship (Type, Print) <i>Gloria Blair niece</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>21117 10829 Sherwood Hill Rd. Orange Mills MD</i>			
	20a. Method of Disposition <i>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Druid Ridge Cemetery</i>		20c. Location - City or Town, State <i>9/2/00 Baltimore, MD</i>		21. Signature of Funeral Service Licensee <i>[Signature]</i>	
	22. Name and Address of Facility <i>Wife's Funeral Home PA 638 N. Belmor St. Baltimore, MD 21217</i>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <i>Cerebral Vascular with right hemiparetic</i> Due to (or as a consequence of): <i>Chronic Renal Insufficiency</i> Due to (or as a consequence of): <i>Non-Insulin-dependent diabetes</i> Due to (or as a consequence of): <i>Hypothyroidism</i>					
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>anemia</i>						23b. Did tobacco use contribute to the cause of death? <i>1 Yes 2 No 3 Probably 4 Unknown</i>		
24a. Was an autopsy performed? <i>1 Yes 2 No</i>						24b. Were autopsy findings available prior to completion of cause of death? <i>1 Yes 2 No</i>		
25. Was case referred to medical examiner? <i>1 Yes 2 No</i>		26. Place of Death (Check only one) Hospital: <i>1 Inpatient 2 ER/Outpatient 3 DOA</i> Other: <i>4 Nursing Home 5 Residence 6 Other (Specify)</i>						
27. Manner of Death <i>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined</i>		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <i>1 Yes 2 No</i>		28d. Describe how injury occurred
29a. Certifier (Check only one) <i>1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.</i> <i>2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.</i>		29b. Signature and title of certifier <i>Allen Rully MD</i>		29c. License number <i>D54749</i>		29d. Date signed (Month, Day, Year) <i>08 31 2000</i>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>St. Elizabeth Nursing Home 3320 Benson Ave. Baltimore, MD.</i>								
31. Date filed (Month, Day, Year) <i>SEP 06 2000</i>		32. Registrar's Signature <i>[Signature]</i>						



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27942

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>NAOMI E. JOHNSON</b>				2. Date of Death Month Day Year <b>SEPT. 3, 2000</b>				3. Time of Death <b>11:50 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>823 EAST LAKE AVENUE</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>				4c. County of Death <b>4/10</b>	
Funeral Director	5. Social Security Number <b>219-30-7014</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>69</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Aug. 25/1931</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>Pennsylvania</b>		10b. County <b>York</b>		10c. City, Town or Location <b>York City</b>				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number <b>24 E. South Street</b>				10f. Zip Code <b>17403</b>		10g. Citizen of What Country? <b>USA</b>			
To Be Completed by Physician/Medical Examiner	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>black</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th grade</b>		College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Custodian</b>				16b. Kind of Business/Industry <b>Church</b>	
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>WILLIAM DAVIS</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Rosalie Gaskins</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>PAMELA GLADDEN / Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>823 E. Lake Ave Baltimore, Maryland 21202</b>					
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Susquehanna Memorial Garden</b>		20c. Location - City or Town, State <b>York, PA</b>		20d. Date <b>9/7/2000</b>			
	21. Signature of Funeral Service Licensee <b>[Signature]</b>		22. Name and Address of Facility <b>CHATELAIN - NARRIS Funeral Home 5240 REISTERSTOWN RD BALTIMORE, MD 21215</b>							
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Arteriosclerotic Cardiovascular Disease</b> Due to (or as a consequence of):  <b>b. Due to (or as a consequence of):</b>  <b>c. Due to (or as a consequence of):</b>  <b>d. Due to (or as a consequence of):</b>									
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown									
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <b>INSPECTION</b> 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No									
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No									
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>AT SCENE</b>									
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier <b>[Signature] M.D.</b>		29c. License number <b>O.C.M.E</b>				29d. Date signed (Month, Day, Year) <b>SEPT. 3, 2000</b>			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201</b>									
	31. Date filed (Month, Day, Year) <b>SEP 6 2000</b>		32. Registrar's Signature <b>[Signature]</b>							

Division of Vital Records, P.O. Box 68760,  
Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.





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State of Maryland / Department of Health and Mental Hygiene

00 27943

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

GORDON PAUL KERN

2. Date of Death

September 5

2000

3. Time of Death

06:15 AM

4a. Facility Name (If not institution, give street and number)

DEATON MEDICAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

220-09-6754

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 19, 1919

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

2818 ORLEANS STREET

10f. Zip Code

21230

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HUCKSTER

16b. Kind of Business/Industry

SELF-EMPLOYED

17. Father's Name (First, Middle, Last)

UNKNOWN

18. Mother's Name (First, Middle, Maiden Surname)

UNKNOWN

19a. Informant's Name/Relationship (Type, Print)

GEORGE MAYO/ FRIEND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7836 EASTDALE ROAD, BALTIMORE, MARYLAND 21224

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GREENMOUNT CEMETERY

Date

9/6/00

20c. Location - City or Town, State

BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

LILLY &amp; ZEILER INC. FUNERAL HOME

1901 EASTERN AVENUE, BALTIMORE, MARYLAND 21231

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e.

Cardiac arrhythmia

15 minutes

Due to (or as a consequence of):

b.

Atherosclerotic heart disease

15 hrs

Due to (or as a consequence of):

c.

Congestive heart failure

5 hrs

Due to (or as a consequence of):

d.

Hypertension

30 hrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 30494

29d. Date signed (Month, Day, Year)

9-5-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KERN, PAUL DEATON MEDICAL CENTER 611 SOUTH CHARLES STREET BALTIMORE MD 21230

31. Date filed (Month, Day, Year)

SEP 06 2000

32. Registrar's Signature

Benita B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760, 2

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27944

AMENDED ITEMS 7,8 PER INFORMANT G787 9/11/00 AH

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Kenneth Kunkle</b>				2. Date of Death Month <b>Sept</b> Day <b>2</b> Year <b>2000</b>		3. Time of Death <b>0700</b>	
	4a. Facility Name (If not institution, give street and number) <b>Anne Arundel Gen. Hosp</b>				4b. City, Town, or Location of Death <b>Annapolis</b>		4c. County of Death <b>AA</b>	
Funeral Director	5. Social Security Number <b>178-22-8634</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>70</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>10/07/1929</b>	
	9. Birthplace (State or Foreign Country) <b>PA.</b>		10. Usual Residence of Decedent 10a. State <b>PA.</b> 10b. County <b>York</b> 10c. City, Town or Location <b>Windsor</b>		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>Peacetime</b>	
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>2</b>		16. Kind of Business/Industry <b>Printing Press Manufacturer</b>		
17. Father's Name (First, Middle, Last) <b>Charles E. Kunkle</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Effie G. Kilburn</b>		19. Informant's Name/Relationship (Type, Print) <b>Edwin C. Kunkle (son)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>229 Dominion Rd. Chester, MD. 21619</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Windsor Church of God</b>		20c. Location - City or Town, State <b>09/06/2000 Windsor, PA.</b>		21. Signature of Funeral Service Licensee <b>William R. Jones</b>		
22. Name and Address of Facility <b>Duda-Ruck Funeral Home of 7922 Wise Ave. Dundalk, MD. 21222</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>a. Arteriosclerotic Heart Disease</b> Due to (or as a consequence of): <b>b. Hypertension</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		
28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Deputy William R. Jones</b>		
29c. License number <b>D06054</b>		29d. Date signed (Month, Day, Year) <b>9/2/00</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>William P. Jones, MD 695 America 21035</b>		31. Date filed (Month, Day, Year) <b>SEP 06 2000</b>		
32. Registrar's Signature <b>Benjamin A. Sparks</b>		State Registrar		33. Date of Death <b>SEP 06 2000</b>		34. Registrar's Signature <b>Benjamin A. Sparks</b>		

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

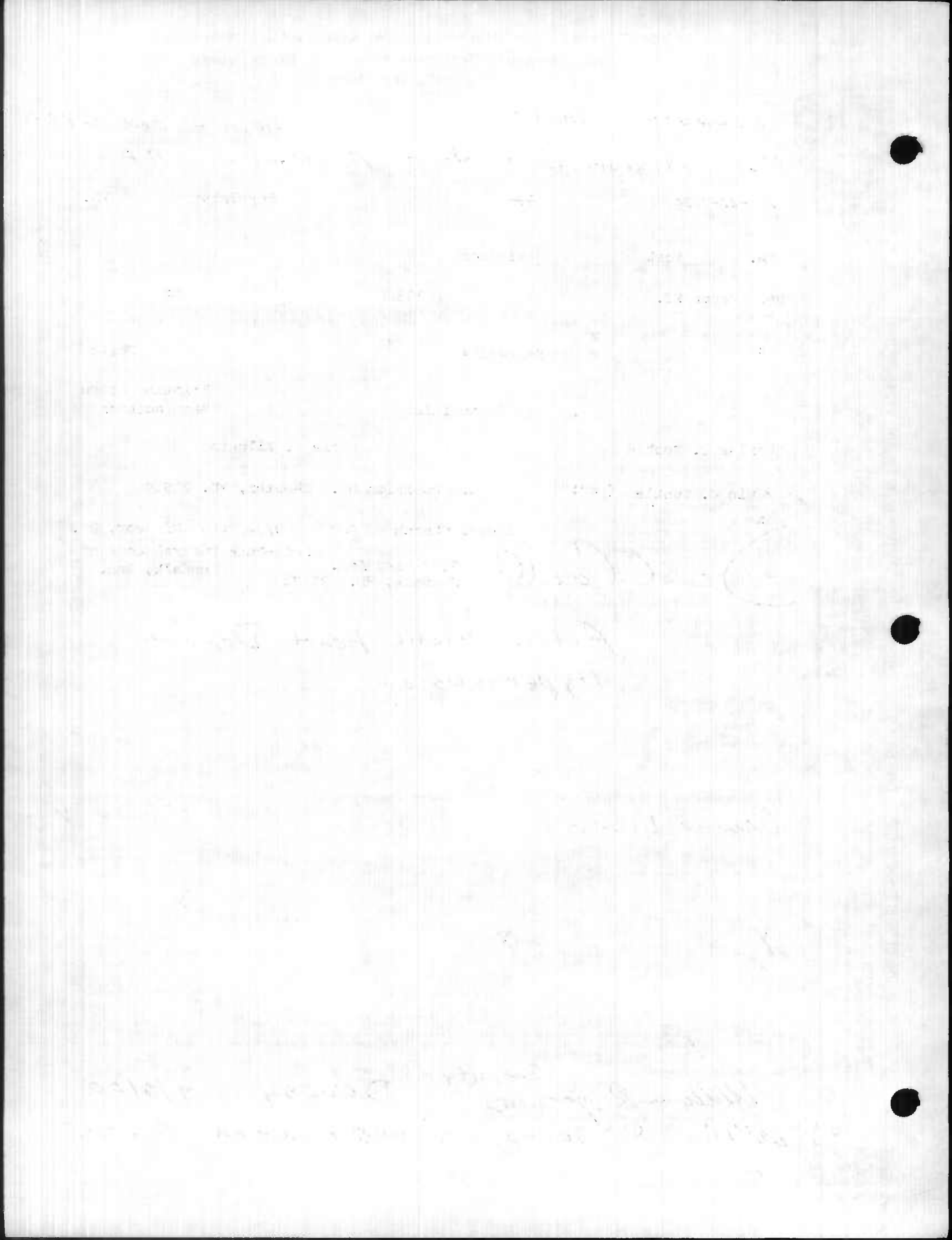
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27945

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>SUSAN KARSHMER</b>		2. Date of Death Month Day Year <b>August 31 2000</b>		3. Time of Death <b>1454</b>
	4a. Facility Name (If not institution, give street and number) <b>Sinai Hospital of Baltimore</b>		4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>
Funeral Director	5. Social Security Number <b>212-80-3149</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>37</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>JUN. 22, 1963</b>		9. Birthplace (State or Foreign Country) <b>MD</b>		
Usual Residence of Decedent					
10a. State <b>MD</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>OWINGS MILLS</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <b>25 OLIVE LANE</b>			10f. Zip Code <b>21117</b>		10g. Citizen of What Country? <b>U.S.A.</b>
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>ADMINISTRATOR</b>		16b. Kind of Business/Industry <b>HEALTH CARE</b>	
17. Father's Name (First, Middle, Last) <b>NORMAN KARSHMER</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>ALLYN ROSEMAN</b>			
19a. Informant's Name/Relationship (Type, Print) <b>NORMAN KARSHMER / FATHER</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2808 QUARRY HEIGHTS WAY - BALTIMORE, MD 21209</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>BALTIMORE HEBREW CEMETERY 9/3/00</b>		20c. Location - City or Town, State <b>REISTERSTOWN, MD</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		a. <b>Septic Shock</b> Due to (or as a consequence of):			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. <b>Alcoholic Liver Disease</b> Due to (or as a consequence of):			
		c. Due to (or as a consequence of):			
		d. Due to (or as a consequence of):			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>P. Ogbogu MD</b>		29c. License number <b>RES 000</b>		29d. Date signed (Month, Day, Year) <b>August 31, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>P. Ogbogu Sinai Hospital of Baltimore</b>					
31. Date filed (Month, Day, Year) <b>SEP 06 2000</b>		32. Registrar's Signature 			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

Physician  
/Medical  
Examiner

Funeral  
Director

Physician  
/Medical  
Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27946

TIMOTHY  
KLINEPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

TIMOTHY PAUL KLINE

2. Date of Death

Month Day Year  
AUGUST 31, 2000

3. Time of Death

5:15P.M.

4a. Facility Name (If not institution, give street and number)

RT. 152 NORTH OF CLOVERDALE DRIVE

4b. City, Town, or Location of Death

FALLSTON

4c. County of Death

HARFORD

Funeral  
Director

5. Social Security Number

219-08-2832

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

16

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
JAN 5, 1984

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

HARFORD

10c. City, Town or Location

JARRETTSTOWN

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

2137 BRONSON COURT

10f. Zip Code

21084

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☒ Never Married ☐ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12 YRS.

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

APPRENTICE PAINTER

16b. Kind of Business/Industry

AUTO BODY SHOP

17. Father's Name (First, Middle, Last)

TIMOTHY P. KLINE

18. Mother's Name (First, Middle, Maiden Surname)

JANET L. STEINBACH

19a. Informant's Name/Relationship (Type, Print)

MR + MRS TIMOTHY P. KLINE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2137 BRONSON COURT JARRETTSTOWN, MARYLAND 21084

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ST. MARY'S CEMETERY

Date

SEP 4, 2000

20c. Location - City or Town, State

PYLESVILLE MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

EVAN FUNERAL CHAPEL - BEL AIR, P.A. 21050  
3 NEWPORT DRIVE FOREST HILL, MARYLAND

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MULTIPLE INJURIES  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☒ Yes ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

☒ Yes ☐ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☒ Other (Specify)

SCENE

27. Manner of Death

☐ Natural☒ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

8/31/00

28b. Time of Injury

1641 PM

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

DRIVER OF CAR STRUCK HEAD ON BY ANOTHER CAR

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

HIGHWAY

28f. Location (Street and Number or Rural Route Number, City or Town, State)

RT 152 JUST NORTH OF CLOVERDALE DR, FALLSTON MD

29a. Certifier (Check only one)

☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

SEPTEMBER 1, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

MARY G. RIPPKE, M.D.

111 Penn Street, Baltimore, Maryland 21201

State  
Registrar

31. Date filed (Month, Day, Year)

SEP 06 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27947

amend item 18 per fh G787 9/6/00 yf

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>VICTOR KALISH</b>		2. Date of Death Month <b>SEPT.</b> Day <b>2</b> Year <b>2000</b>		3. Time of Death <b>5:53AM</b>
	4a. Facility Name (If not institution, give street and number) <b>16 BITTERROOT COURT APT. F.</b>		4b. City, Town, or Location of Death <b>OWINGS MILLS</b>		4c. County of Death <b>BALTIMORE</b>
Funeral Director	5. Social Security Number <b>215-43-7146</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>70</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>JULY 5 1930</b>		9. Birthplace (State or Foreign Country) <b>RUSSIA</b>		
Usual Residence of Decedent					
10a. State <b>MD</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>OWINGS MILLS</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <b>16 BITTERROOT COURT APT. F</b>			10f. Zip Code <b>21117</b>		10g. Citizen of What Country? <b>ASIA</b>
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Years		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SALESMAN</b>		16b. Kind of Business/Industry <b>RETAIL</b>	
17. Father's Name (First, Middle, Last) <b>AARON KALISH</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Gerta Frek (UNKNOWN)</b>		
19a. Informant's Name/Relationship (Type, Print) <b>IDEYA KALISH/WIFE</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>16 BITTERROOT COURT APT. F OWINGS MILLS, MD. 21117</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>BALTIMORE HEBREW</b>		20c. Location - City or Town, State <b>9/3/00 REISTERSTOWN, MD.</b>	
21. Signature of Funeral Service Licensee <i>Michael Lopez</i>		22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Metastatic Adenocarcinoma of Unknown Primary Type!</b> Dua to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>Philip Konits M.D.</b>		29c. License number <b>D24321</b>		29d. Date signed (Month, Day, Year) <b>9/2/00</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>PHILIP KONITS 821 EUTAW STREET BACON, MD</b>					
31. Date filed (Month, Day, Year) <b>SEP 06 2000</b>		32. Registrar's Signature <i>Benjamin B. Spaulding</i>			

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27948

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>SIDNEY LOVE JR.</b>		2. Date of Death Month <b>9</b> Day <b>1</b> Year <b>2000</b>		3. Time of Death <b>3:15 AM</b>
	4a. Facility Name (If not institution, give street and number) <b>BON SECOURS HOSPITAL</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>NA</b>
Funeral Director	5. Social Security Number <b>220-84-1034</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>75</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>MAY 2, 1925</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State <b>MD</b>		10b. County <b>NA</b>
	10c. City, Town or Location <b>BALTIMORE</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>30 S. ATHOL AVENUE</b>		10f. Zip Code <b>21229</b>		10g. Citizen of What Country? <b>USA</b>
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>0</b> College (1-4 or 5+) <b>NA</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>NEVER WORKED</b>
	16b. Kind of Business/Industry <b>NA</b>		17. Father's Name (First, Middle, Last) <b>Sidney LOVE SR.</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>UNKNOWN</b>
	19a. Informant's Name/Relationship (Type, Print) <b>Gloria Grant / Guardian</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>616 Glenolden Avenue, Balto, MD 21216</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Zion Cemetery</b>		20c. Location - City or Town, State <b>9/6/00 Landsdowne, MD</b>
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>WYLF FUNERAL HOME P.A. 638 N. GILMOR STREET BALTIMORE, MD 21217</b>		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>SEPTICEMIA</b>  Due to (or as a consequence of): <b>ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE</b>  Due to (or as a consequence of): <b>RENAL FAILURE</b>  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Approximate Interval Between Onset and Death				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined					
28a. Date of Injury (Month, Day Year) <b>9/6/00</b>					
28b. Time of Injury <b>M</b>					
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>Rosita R. Cruz M.D.</b>					
29c. License number <b>D0030355</b>					
29d. Date signed (Month, Day, Year) <b>September 1, 2000</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ROSITA R. CRUZ M.D. BON SECOURS HOSPITAL</b>					
31. Date filed (Month, Day, Year) <b>SEP 06 2000</b>					
32. Registrar's Signature 					





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

amend item 10b,10c per fh G787 9/6/00 yf

00 27949

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

EUGENE M. LLOYD

2. Date of Death

Month Day Year

September 3 2000

3. Time of Death

4:05 PM

4a. Facility Name (If not institution, give street and number)

UPA Funeral Home

4b. City, Town, or Location of Death

Green Spring

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

217-16-8309

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days Hours Min.

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Jan. 15 1924

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Anne Arundel Co.

10c. City, Town or Location

Baltimore

Pasadena

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

699 Wise Ave.

10f. Zip Code

21122

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☐ No

If Yes, Give Year or Dates: 1942-44

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

11 0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Machinist

16b. Kind of Business/Industry

International Paper

17. Father's Name (First, Middle, Last)

Unkown

Lloyd

18. Mother's Name (First, Middle, Maiden Surname)

Anna Cecilia

Unkown

19a. Informant's Name/Relationship (Type, Print)

Shawn Smith (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

699 Wise Ave. Pasadena, Md. 21122

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery

Date

9/07/2000

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

Robert Pickett

22. Name and Address of Facility

McCully-Polyniak Funeral Home P.A.

3204 Mountain Road, Pasadena, Md. 21122

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Chronic obstructive lung disease

b. Acute respiratory failure

c. Hypoxia

d. Corrupt brain disease

Approximate Interval Between Onset and Death

4 days

2 days

1 day

4 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Aneurysm

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. [Signature]

29c. License number

D46261

29d. Date signed (Month, Day, Year)

September 3, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

501 Harper Drive Green Spring and 21146

31. Date filed (Month, Day, Year)

SEP 06 2000

32. Registrar's Signature

[Signature]

State Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27950

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Dorothy Mae Lister

2. Date of Death

September 1, 2000

3. Time of Death

6:14AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Sinai Hospital of Baltimore

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

City

5. Social Security Number

217-50-6453

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

52 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct. 9, 1947

9. Birthplace (State or Foreign)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Owings Mills

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

127 Allgate Rd.

10f. Zip Code

21117

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Medical Billing

16b. Kind of Business/Industry

Medical Lab

17. Father's Name (First, Middle, Last)

Lester Arthur Lindenmuth

18. Mother's Name (First, Middle, Maiden Surname)

Dorothy Mae Cinquars

19a. Informant's Name/Relationship (Type, Print)

William Robert Kreipl

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

127 Allgate Rd. Owings Mills, Md. 21117

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Evergreen Mem. Gardens Sept. 5, 2000 Finksburg, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

H. Ehlhardt

22. Name and Address of Facility

Eckhardt Funeral Chapel  
11605 Reisterstown Rd. Owings Mills, Md. 2111723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Metastatic cancer

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

6 weeks

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

28. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury et  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29e. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Henry L MD

29c. License number

RES 000

29d. Date signed (Month, Day, Year)

September 1, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HENRY TAN, Sinai Hospital of Baltimore, 2401 WEST BELVEDERE AVE, BALTIMORE, MD 21215

31. Date filed (Month, Day, Year)

SEP 06 2000

32. Registrar's Signature

Sparks

State  
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-d show any injury or other traumatic event, the Medical Examiner must be notified at once.

University of Illinois

Chicago, Ill., U.S.A.

1947-1948

1947-1948

University of Illinois

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1947-1948

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University of Illinois

University of Illinois

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University of Illinois

1947-1948

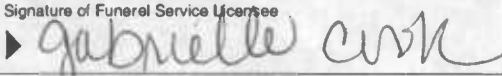
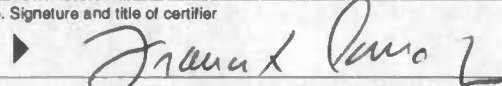

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27951

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Martha J. Moore</b>				2. Date of Death Month <b>Aug.</b> Day <b>31</b> Year <b>2000</b>				3. Time of Death <b>1308pm</b>		
	4a. Facility Name (If not institution, give street and number) <b>2116 Cliftwood Avenue</b>				4b. City, Town, or Location of Death <b>Baltimore</b>				4c. County of Death <b>NA</b>		
Funeral Director	5. Social Security Number <b>217-24-8538</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>72</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>07-17-28</b>		9. Birthplace (State or Foreign Country) <b>SC</b>		
	Usual Residence of Decedent										
10a. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number <b>2116 Cliftwood Avenue</b>				10f. Zip Code <b>21213</b>				10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6th Grade</b> College (1-4 or 5+) <b>NA</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Housewife</b>				16b. Kind of Business/Industry <b>in home</b>			
17. Father's Name (First, Middle, Last) <b>John Coleman</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Andrena Coleman</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Pastor Timothy Moore</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4 S. Treemont Road Baltimore, Maryland 21229</b>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Garrison Forest VA Cem. 09-06-2000 Owings Mills</b>			20c. Location - City or Town, State <b>MD</b>					
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>MYOCARDIAL INFARCTION</b> Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):										Approximate Interval Between Onset and Death <b>SAME</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
										24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
										24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier 					29c. License number <b>D01373</b>		29d. Date signed (Month, Day, Year) <b>9-1-2000</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>FRANCIS X. CARMODY, M.D. 7505 OSLER DR. #212 TOWSON, MD 21204</b>											
31. Date filed (Month, Day, Year) <b>SEP 06 2000</b>					32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27952

AMENDED ITEM #10e PER FH G787 9/6/00 AH

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Luke Maddox Sr.</b>		2. Date of Death Month <b>August</b> Day <b>31</b> Year <b>2000</b>		3. Time of Death <b>2:20am</b>
	4a. Facility Name (If not institution, give street and number) <b>4711 Frederick Ave</b>		4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death
Funeral Director	5. Social Security Number <b>258-18-9056</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>88</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>01 15 12</b>	9. Birthplace (State or Foreign Country) <b>G.A.</b>
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>NA</b>	10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <b>4711 FREDERICK AVE. 221 South Catherine Street</b>		10f. Zip Code <b>21229</b>		10g. Citizen of What Country? <b>U.S.A.</b>
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>Black</b>
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th grade</b> College (1-4 or 5+) <b>na</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Cement Finisher</b>		16b. Kind of Business/Industry <b>Drummond Cement Co.</b>
	17. Father's Name (First, Middle, Last) <b>J.D. Maddox</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Lela Maddox</b>		
Physician /Medical Examiner	19e. Informant's Name/Relationship (Type, Print) <b>Samuel Maddox-Son</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4711 Frederick Ave, Baltimore Md 21229</b>		
	20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cedar Hill Cemetery</b>		20c. Location - City or Town, State <b>Glen Burnie, Md</b>
	21. Signature of Funeral Service Licensee <i>John B. Johnson Jr.</i>		22. Name and Address of Facility <b>March F/H West 4300 Wabash Ave, Baltimore Md 21215</b>		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  e. <b>Metastatic Lung Carcinoma</b> Due to (or as a consequence of): b. <b>Lung Cancer</b> Due to (or as a consequence of): c. <b>Hypertension</b> Due to (or as a consequence of): d. <b>old OVA</b>				
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
State Registrar	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
	29b. Signature and title of certifier <i>Gubali M. Shih MD</i>		29c. License number <b>D26750</b>		29d. Date signed (Month, Day, Year) <b>9/1/00</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>2300 Garrison Boulevard Garrison Medical Center Suite 100, Baltimore Md 21216</b>					
31. Date filed (Month, Day, Year) <b>SEP 06 2000</b>		32. Registrar's Signature <i>[Signature]</i>			

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27953

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Richard C Moore</i>						2. Date of Death Month <i>September</i> Day <i>15</i> Year <i>2000</i>		3. Time of Death <i>1:20 AM</i>	
	4a. Facility Name (If not institution, give street and number) <i>Good Samaritan Nursing Home</i>						4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>1/A</i>	
Funeral Director	5. Social Security Number <i>217-24-7140</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>77</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>4-10-1923</i>		9. Birthplace (State or Foreign Country) <i>Va</i>	
	Usual Residence of Decedent									
10a. State <i>MD.</i>		10b. County <i>1/A</i>		10c. City, Town or Location <i>Baltimore</i>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <i>1329 N. LUCERNE AVE.</i>				10f. Zip Code <i>21213</i>		10g. Citizen of What Country? <i>U. S. A.</i>				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>8th grade</i> College (1-4 or 5+) <i>1/A</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Home Maker</i>			16b. Kind of Business/Industry <i>Home Maker</i>			
17. Father's Name (First, Middle, Last) <i>Willie Lewis</i>						18. Mother's Name (First, Middle, Maiden Surname) <i>Eula (Unknown)</i>				
19a. Informant's Name/Relationship (Type, Print) <i>Hansberry Moore (son)</i>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1175 E. Northern Parkway Balto. Md.</i>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Garson Forest Cem.</i>			20c. Location - City or Town, State <i>9/2000 Casns Mills, Md.</i>				
21. Signature of Funeral Service Licensee <i>Patricia Bitt</i>						22. Name and Address of Facility <i>Betts Funeral Home 21213 1129 N. Caroline Street Balto. Md.</i>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <i>Cancer Bladder</i> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death <i>2 Months</i>
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of causa of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
			28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <i>Shresh K. Tripuraneni</i>				29c. License number <i>D 30661</i>		29d. Date signed (Month, Day, Year) <i>September 15 2000</i>				
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) <i>SIREESH TRIPURANENI 1601 East Belvedere, Baltimore, Md - 21239</i>										
31. Date filed (Month, Day, Year) <i>SEP 06 2000</i>			32. Registrar's Signature <i>Benita B. Sparks</i>							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27954

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARTHA ELIZABETH MUMLEY

2. Date of Death

Month Day Year  
September 03, 2000

3. Time of Death

1:32 P.M.

4a. Facility Name (If not institution, give street and number)

St. Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

369-42-4540

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

57 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
JAN. 4, 1943

9. Birthplace (State or Foreign Country)

MICHIGAN

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

PHOENIX

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

25 CONSTATIVE DRIVE

10f. Zip Code

21131

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation

(Give kind of work done during most of working  
life. DO NOT use retired)

ADMINISTRATIVE ASSISTANT

16b. Kind of Business/Industry

COMMUNITY COLLEGE  
OF BALTIMORE COUNTY

17. Father's Name (First, Middle, Last)

JOHN LEFEVRE, SR.

18. Mother's Name (First, Middle, Maiden Surname)

MARY MOTTERAM

19a. Informant's Name/Relationship (Type, Print)

RICHARD M. MUMLEY, SPOUSE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

25 CONSTATIVE DR. PHOENIX, MD. 21131

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)EVANS FUNERAL CHAPEL  
BELAIR - P.A.

Date

SEPT. 5  
2000

20c. Location - City or Town, State

FOREST HILL, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

EVANS FUNERAL CHAPEL  
8800 HARFORD RD. PARKVILLE, MD. 2123423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)PULMONARY THROMBOEMBOLISM DUE TO DEEP VENOUS THROMBOSIS OF THE  
LOWER EXTREMITIESa. ~~Pulmonary embolism due to deep venous~~  
Due to (or as a consequence of): ~~thrombosis of the lower~~  
~~extremities~~Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Lung cancer

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide 6 ☐ Could not be  
determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

September 05, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201

State  
Registrar

31. Date filed (Month, Day, Year)

SEP 06 2000

32. Registrar's Signature

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27955

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JOHN CARLTON MONGAN</b>			2. Date of Death Month Day Year <b>SEPTEMBER 02, 2000</b>		3. Time of Death <b>11:20 P.M.</b>			
	4a. Facility Name (If not institution, give street and number) <b>TROYER ROAD at THE HARFORD COUNTY LINE</b>			4b. City, Town, or Location of Death <b>HEREFORD</b>		4c. County of Death <b>BALTIMORE</b>			
Funeral Director	5. Social Security Number <b>217-58-6166</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>38</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>MARCH 24, 1962</b>			
	9. Birthplace (State or Foreign Country) <b>MD.</b>								
Usual Residence of Decedent									
10a. State <b>MD</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>PARKTON</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number <b>20772 OLD YORK RD.</b>				10f. Zip Code <b>21120</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>ELECTRICIAN</b>			16b. Kind of Business/Industry <b>RIGGS DISTLER</b>			
17. Father's Name (First, Middle, Last) <b>ROBERT E. MONGAN, SR.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>JACQUELINE E. FEDERER</b>					
19a. Informant's Name/Relationship (Type, Print) <b>ROBERT E. MONGAN, SR.</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11500 GLENARM RD. GLENARM, MD. 21057</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>DULANEY VALLEY MEM. GDNS.</b>		Date <b>SEPT. 6 2000</b>		20c. Location - City or Town, State <b>TIMONIUM, MD.</b>			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>EVANS FUNERAL CHAPEL 3300 HARFORD RD. PARKVILLE, MD. 21234</b>					
23a. Enter the disease or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. MULTIPLE INJURIES</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b>							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>9-2-00</b>		28b. Time of Injury <b>2305 P M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
		28d. Describe how injury occurred <b>MOTORCYCLIST STRUCK GUARDRAIL(S)</b>		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>ROADWAY</b>					
		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>TROYER RD BALTIMORE CO - MD</b>							
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier 				29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>SEPTEMBER 03, 2000</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>HAROLD A. KORON MD 111 Penn Street, Baltimore, Maryland 21201</b>									
31. Date filed (Month, Day, Year) <b>SEP 06 2000</b>				32. Registrar's Signature 					

10

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

A-4



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27956

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Margaret Merkel

2. Date of Death

Month Day Year  
Sept. 3, 2000

3. Time of Death

5:15am

4a. Facility Name (If not institution, give street and number)

Augsburg Home

4b. City, Town, or Location of Death

Woodlawn

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

215-10-8545

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

88

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 20, 1911

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Woodlawn

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

6811 Campfield Rd.

10f. Zip Code

21207

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

John Miller

18. Mother's Name (First, Middle, Maiden Surname)

Catherine Diamond

19a. Informant's Name/Relationship (Type, Print)

Alfred J. Merkel, son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1217 Circle Dr. Arbutus, MD. 21227

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Meadowridge Memorial Park 9-6-00

Date

20c. Location - City or Town, State

Elkridge, MD

21. Signature of Funeral Service Licensee

Rebecca Leach

22. Name and Address of Facility

Ambrose Funeral Home, Inc.

1328 Sulphur Spring Rd. Arbutus, MD. 21227

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Alzheimer's Disease

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. \_\_\_\_\_  
Due to (or as a consequence of):c. \_\_\_\_\_  
Due to (or as a consequence of):d. \_\_\_\_\_  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Raymond Miller MD

29c. License number

D 47683

29d. Date signed (Month, Day, Year)

9/5/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Raymond Miller 25 Main Street Suite 200 Pikesville MD

31. Date filed (Month, Day, Year)

SEP 06 2000

32. Registrar's Signature

Raymond Miller

State  
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27957

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary E. McGinnis

2. Date of Death

Month 09 Day 04 Year 2000

3. Time of Death

12:45 PM

4a. Facility Name (If not institution, give street and number)

Caton Manor Nursing Home

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

214-64-7624

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
05/01/1912

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

XX Yes 2 ☐ No

10e. Street and Number

3611 Hineline Road

10f. Zip Code

21229

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

William Holmes

18. Mother's Name (First, Middle, Maiden Summa)

Cecelia Brewer

19a. Informant's Name/Relationship (Type, Print)

Sharon F. Ritch / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3611 Hineline Rd. Balto., MD 21229

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Balto. Natl' Cemetery

Date

9/7/00

20c. Location - City or Town, State

Catonsville, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Ambrose Funeral Home

1328 Sulphur Spring Road, Arbutus, MD 21227

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

End stage Dementia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Unknown

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] MD

29c. License number

D27569

29d. Date signed (Month, Day, Year)

9/15/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Allen Kettelman 1538 Greene Tree Rd #300

31. Date filed (Month, Day, Year)

SEP 06 2000

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Mary Elizabeth McGinnis

A74





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27958

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Charles McGonigal</b>				2. Date of Death Month <b>August</b> Day <b>29</b> Year <b>2000</b>		3. Time of Death <b>10:55AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>North Arundel Hospital</b>				4b. City, Town, or Location of Death <b>Glen Burnie</b>		4c. County of Death <b>Anne Arundel</b>	
Funeral Director	5. Social Security Number <b>234 58 1624</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>62</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Oct. 8, 1937</b>	
	9. Birthplace (State or Foreign Country) <b>West Virginia</b>		10a. State <b>Maryland</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Linthicum</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number <b>6819 Balto. Annapolis Blvd.</b>		10f. Zip Code <b>21090</b>	
	10g. Citizen of What Country? <b>U.S.</b>				11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10th</b> College (1-4 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Sign Painter</b>				16b. Kind of Business/Industry <b>Sign Co.</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Charles Cotton</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Maggie P. Taylor</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Christa McGonigal / Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6819 Balto. Annapolis Blvd. Linthicum, Md. 21090</b>			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Bayview Crematory, Inc.</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225</b>			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Metastatic Lung Cancer</b> Due to (or as a consequence of): <b>Lung Cancer</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Lung Cancer</b> Due to (or as a consequence of):  <b>c. Lung Cancer</b> Due to (or as a consequence of):  <b>d. Lung Cancer</b> Due to (or as a consequence of):						Approximate Interval Between Onset and Death <b>1 month</b> <b>2 yrs.</b>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		28g. Location (Street and Number or Rural Route Number, City or Town, State)	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						29b. Signature and title of certifier 	
	29c. License number <b>031551</b>						29d. Date signed (Month, Day, Year) <b>August 29, 2000</b>	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Russell R. Oelum 1600 S. Crain Highway, Glen Burnie, Md. 21061</b>						31. Date filed (Month, Day, Year) <b>SEP 06 2000</b>	
	32. Registrar's Signature 						33. Registrar's Signature 	



00 27959

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

00 27960

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HAZEL E. MARINER</b>				2. Date of Death Month Day Year <b>SEPTEMBER 2, 2000</b>		3. Time of Death <b>5:30 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>SINAI HOSPITAL OF BALTIMORE</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>212-09-5568</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>89</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>NOV. 7, 1910</b>		9. Birthplace (State or Foreign Country) <b>MD.</b>
	Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>PERRY HALL, MD</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>4405 CARMELLIA RD</b>				10f. Zip Code <b>21236</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4or 5+) <b>N/A</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOME MAKER</b>		16b. Kind of Business/Industry <b>Home.</b>		
17. Father's Name (First, Middle, Last) <b>ARTHUR BRANDENBURG</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>NANCY POWELL</b>				
19a. Informant's Name/Relationship (Type, Print) <b>John Marley</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4405 CARMELLIA RD. BALTO. MD 21236</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>WOOD LAWN CEM.</b>		Date <b>9/6/00</b>		20c. Location - City or Town, State <b>BALTO MD.</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>HARTLEY MILLER FUNERAL HOME CHD. 7527 HARTFORD RD. BALTO MD 21234</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>ACUTE MYOCARDIAL INFARCTION</b> Due to (or as a consequence of): <b>ATHEROSCLEROTIC HEART DISEASE</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>RIGHT HIP FRACTURE</b>								Approximate Interval Between Onset and Death <b>1 Day</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>RIGHT HIP FRACTURE</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>AUGUST 31, 00</b>		28b. Time of Injury <b>UNK M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>FALL AT RESIDENCE HOME</b>
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>NURSING HOME</b>				28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>2211-W. ROGERS AVE WESTLEY NURSING HOME BALTO, MD</b>				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <b>BENNY TAN MD</b>				29c. License number <b>RES 000</b>		29d. Date signed (Month, Day, Year) <b>SEPTEMBER 2, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>BENNY TAN MD SINAI HOSPITAL OF BALTIMORE</b>								
31. Date filed (Month, Day, Year) <b>SEP 06 2000</b>				32. Registrar's Signature 				

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27961

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Charles E. McDevitt, Sr.				2. Date of Death Month Day Year September 2, 2000		3. Time of Death 8:00 PM	
	4a. Facility Name (If not institution, give street and number) 112 Summit Avenue				4b. City, Town, or Location of Death Glen Burnie		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 219-16-7062		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 75 Yrs.		8. Date of Birth (Month, Day, Year) May 2, 1925	
	9. Birthplace (State or Foreign Country) Baltimore, MD		10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Glen Burnie	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 112 Summit Avenue		10f. Zip Code 21060		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1943-1946		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Marble Mason		16b. Kind of Business/Industry B Green Cash and Carry			
	17. Father's Name (First, Middle, Last) William B. McDevitt				18. Mother's Name (First, Middle, Maiden Surname) Genevieve Hersch			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Randall McDevitt - Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 105 Beach Road, Glen Burnie, MD 21060			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park Cemetery		20c. Location - City or Town, State 9.5.00 Baltimore, MD		21. Signature of Funeral Service Licensee Kelly Gregory Fink	
To Be Completed by Physician/Medical Examiner	22. Name and Address of Facility FINK FUNERAL HOME, PA 426 Crain Hwy., SW, Glen Burnie, MD 21061				23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Chronic Obstructive Pulmonary Disease Due to (or as a consequence of): b. Cerebrovascular Accident Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			
	23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			
To Be Completed by Physician/Medical Examiner	28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier MD		29c. License number D50108		29d. Date signed (Month, Day, Year) 9/5/00			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7845 Oakwood Rd, Suite 201, Glen Burnie, MD 21061							
State Registrar	31. Date filed (Month, Day, Year) SEP 06 2000		32. Registrar's Signature Benita B. Sparks					

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27962

cm

Dorothy Nichols

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Dorothy Helena Nichols</b>		2. Date of Death Month Day Year <b>September 01, 2000</b>		3. Time of Death <b>12:30 P.M.</b>
	4a. Facility Name (If not institution, give street and number) <b>1525 Locust Street</b>		4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>
Funeral Director	5. Social Security Number <b>212 24 9051</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>72</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>Jan. 17, 1928</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
Usual Residence of Decedent					
10a. State <b>W. Va.</b>		10b. County <b>Jefferson</b>		10c. City, Town or Location <b>Charlestown</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <b>405 W. Liberty Street</b>			10f. Zip Code <b>25414</b>		10g. Citizen of What Country? <b>U.S.</b>
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>
17. Father's Name (First, Middle, Last) <b>James Bandock</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Theresa Szabelska</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Robert Nichols / Son</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>405 W. Liberty Street Charlestown, W. Va. 25414</b>		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Bayview Crematory, Inc.</b>		Date <b>9/4/00</b>	20c. Location - City or Town, State <b>Baltimore, Maryland</b>
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Arteriosclerotic Cardiovascular Disease</b> Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <b>Inspection</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) at scene					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>September 01, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dennis Chute M.D. 111 Penn Street, Baltimore, Maryland 21201</b>					
31. Date filed (Month, Day, Year) <b>SEP 06 2000</b>		32. Registrar's Signature 			

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27963

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIAM DAVID OAKES, JR.				2. Date of Death Month Day Year September 3 2000		3. Time of Death 11:15 pm	
	4a. Facility Name (If not institution, give street and number) Franklin Square Hospital Center				4b. City, Town, or Location of Death Rosedale		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 213-34-6838		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 63 Yrs.		8. Date of Birth (Month, Day, Year) April 18 1937	
	9. Birthplace (State or Foreign Country) New Jersey		10a. State Md.		10b. County n/a		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				10e. Street and Number 5554 Whitby Road		10f. Zip Code 21206	
	10g. Citizen of What Country? USA				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: white		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver				16b. Kind of Business/Industry Truck Company		17. Father's Name (First, Middle, Last) William Oakes Sr.	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) Dorothy Lentz				19a. Informant's Name/Relationship (Type, Print) Ralph Oakes (Son)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5554 Whitby Road, Baltimore, Md. 21206	
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery		20c. Location - City or Town, State Baltimore, Md.	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Richard Pickett				22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 237 E. Patapsco Ave. Baltimore, Md. 21225		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Gram Negative Sepsis Due to (or as a consequence of): b. Metastatic Colon Cancer with Liver Failure Due to (or as a consequence of): c. Due to (or as a consequence of): d.	
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day, Year)				28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier John Coffey MD (Coffey)		29c. License number D0055010	
To Be Completed by Physician/Medical Examiner	29d. Date signed (Month, Day, Year) September 3, 2000				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John Coffey MD, 9000 Franklin Square Drive, Baltimore, Maryland 21237		31. Date filed (Month, Day, Year) SEP 06 2000	
	32. Registrar's Signature S. Sparks				33. State Registrar SEP 06 2000		34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27964

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DONALD FREDERICK OBRECHT Sr.

2. Date of Death  
Month Day Year

September 3, 2000 6:50pm

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Greater Baltimore Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

216-16-8785

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug. 14, 1922

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Ruxton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7522 Lhironnelle Club Road

10f. Zip Code

21204

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 1942-1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Realtor

16b. Kind of Business/Industry

Real Estate

17. Father's Name (First, Middle, Last)

JACOB

OBRECHT

18. Mother's Name (First, Middle, Maiden Surname)

CATHERINE ROSETTA WHITE

19a. Informant's Name/Relationship (Type, Print)

Mrs. Carolyn Obrecht (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7522 Lhironnelle Club Rd. Ruxton, Maryland 21204

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Greenmount Crematory

Date

9/5/00

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Robert M. Kratz

22. Name and Address of Facility

Mitchell-Wiedefeld Funeral Home Inc.

6500 York Rd. Baltimore, Maryland 21212

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac Arrest

Due to (or as a consequence of):

b. Pulmonary Fibrosis

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Arrhythmia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

M. Schwartz MD

29c. License number

B-44728

29d. Date signed (Month, Day, Year)

9-5-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. M. Schwartz - GBMC - Balto, Md.

31. Date filed (Month, Day, Year)

SEP 05 2000

32. Registrar's Signature

[Signature]

State Registrar

Obrecht Sr. Donald F.  
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27965

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Thomas Phelan</i>				2. Date of Death Month <i>August</i> Day <i>31</i> Year <i>2000</i>		3. Time of Death <i>7:02 PM</i>		
	4a. Facility Name (If not institution, give street and number) <i>Northwest Hospital</i>				4b. City, Town, or Location of Death <i>RANDALLSTOWN</i>		4c. County of Death <i>Baltimore</i>		
Funeral Director	5. Social Security Number <i>220-18-4356</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <i>74</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>April 10, 1926</i>		
	9. Birthplace (State or Foreign Country) <i>Baltimore, Md.</i>		10a. State <i>Md.</i>		10b. County <i>Baltimore</i>		10c. City, Town or Location <i>Pikesville</i>		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <i>224 Sudbrook Lane</i>		10f. Zip Code <i>21208</i>		10g. Citizen of What Country? <i>U.S.A.</i>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <i>W.W.II</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>White</i>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (14 or 5+) <i>+4</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Insurance Underwriter</i>		16b. Kind of Business/Industry <i>Life Insurance</i>					
17. Father's Name (First, Middle, Last) <i>Patrick Carey Phelan Sr.</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Mary Joseph Peach</i>					
19a. Informant's Name/Relationship (Type, Print) <i>Patricia Ann Phelan - wife</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>224 Sudbrook Lane Pikesville, Md. 21208</i>					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Metro Crematory</i>		20c. Date <i>Sept. 1, 2000</i>		20d. Location - City or Town, State <i>Baltimore, Md.</i>			
21. Signature of Funeral Service Licensee <i>Justin R. Dunbar</i>				22. Name and Address of Facility <i>Eckhardt Funeral Chapel</i> <i>11605 Reisterstown Rd. Owings Mills, Md. 21117</i>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. <i>Myocardial infarction</i> Due to (or as a consequence of):  b. <i>Alcoholism</i> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):		Approximate Interval Between Onset and Death					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Dr. C. Fortenberry</i>		29c. License number <i>A44955</i>		29d. Date signed (Month, Day, Year) <i>8/31/00</i>			
30. Name and address of person who completed cause of death (from 23a) (Type, Print) <i>DEWITT C. FORTENBERRY MD</i>		31. Date filed (Month, Day, Year) <i>SEP 06 2000</i>		32. Registrar's Signature <i>Sparks</i>					
State Registrar									

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Page 1, 1st Edition, 1911

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27966

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Joan Marie Piscano				2. Date of Death Month Day Year September 1 2000				3. Time of Death 2337	
	4a. Facility Name (If not institution, give street and number) Sinai Hospital				4b. City, Town, or Location of Death Baltimore				4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 217-30-4426		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 65 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) August 18, 1935		9. Birthplace (State or Foreign Country) Maryland		Usual Residence of Decedent		10e. State Maryland		10b. County Baltimore	
To Be Completed by Funeral Director	10c. City, Town or Location Owings Mills		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 909 Academy Avenue		10f. Zip Code 21117		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary (K-12) Secondary (13-12) College (1-4 or 5+)	
	16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Apparel Associate		16b. Kind of Business/Industry Sales		17. Father's Name (First, Middle, Last) Oliver Koerber		18. Mother's Name (First, Middle, Maiden Surname) Neva Satterfield		19a. Informant's Name/Relationship (Type, Print) Barbara Brown/Daughter	
	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1565 Marco Drive, Pasadena, Maryland 21122		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park Cemetery		Date 9-6-00		20c. Location - City or Town, State Baltimore, Maryland	
	21. Signature of Funeral Service Licensee Poni Holland		22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Avenue, Baltimore, Maryland 21229		23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. acute myocardial infarction Due to (or as a consequence of): b. Coronary Thrombosis Due to (or as a consequence of): c. Coronary atherosclerosis Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
	24. Immediate Cause (Final disease or condition resulting in death) Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Dr. Paul Gurbel	
	29c. License number D34366		29d. Date signed (Month, Day, Year) 9/5/00		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dr. Paul Gurbel		31. Date filed (Month, Day, Year) SEP 06 2000		32. Registrar's Signature [Signature]	

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27967

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

GENEVIEVE PIATKOWSKI

2. Date of Death

Month Day Year  
AUGUST 31, 2000 9:10am

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death

GLEN BURNIE

4c. County of Death

AA COUNTY

5. Social Security Number

070 30 4263

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb 27, '23

9. Birthplace (State or Foreign Country)

NEW YORK

Usual Residence of Decedent

10a. State

MD

10b. County

ANNE ARUNDEL

10c. City, Town or Location

PASADENA

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

217 ARUNDEL RD

10f. Zip Code

21122

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

SECRETARY

16b. Kind of Business/Industry

POLICE DEPARTMENT

17. Father's Name (First, Middle, Last)

MICHAEL SUSCHINSKI

18. Mother's Name (First, Middle, Maiden Surname)

FRANCES STANCZJK

19a. Informant's Name/Relationship (Type, Print)

KATHRYN A. LITTLE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

217 ARUNDEL RD PASADENA, MD 21122

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

ST MARY'S CEMETERY

Date

9/4/00

20c. Location - City or Town, State

ROME, NY

21. Signature of Funeral Service Licensee

Sharon Mayangle

22. Name and Address of Facility

4001 RITCHIE HWY  
GONCE FUNERAL HOME BALTIMORE, MD 21225

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Cerebrovascular accident

One day

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Atherosclerotic cerebrovascular disease

years.

Due to (or as a consequence of):

c. Multiinfarct dementia

4 years.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending

Investigation

2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Attending Physician

29c. License number

D44973

29d. Date signed (Month, Day, Year)

August 31 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GURMEET S. SAWHNEY MD

325 Hospital Drive Sht. 202  
GLEN BURNIE MD - 21061

31. Date filed (Month, Day, Year)

SEP 06 2000

32. Registrar's Signature

[Signature]

State  
Registrar

March 28, 1900

Dear Mr. [illegible]

[illegible]

Received of [illegible]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27968

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ANNA MARIE POYER</b>				2. Date of Death Month <b>August</b> Day <b>30</b> Year <b>2000</b>		3. Time of Death <b>10:45 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>8810 WALTHER BLVD. APT. 3311</b>				4b. City, Town, or Location of Death <b>LARNEY</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>217 99 0181</b>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>34</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>MAY 4, 1916</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>
	Usual Residence of Decedent							
10a. State <b>MARYLAND</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>LARNEY</b>		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number <b>8810 WALTHER BLVD. APT. 3311</b>				10f. Zip Code <b>21234</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 YRS.</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>BEAUTICIAN</b>		16b. Kind of Business/Industry <b>DEPARTMENT STORE</b>		
17. Father's Name (First, Middle, Last) <b>FRANK KUTCHER</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>LAURA JACOBS</b>				
19a. Informant's Name/Relationship (Type, Print) <b>JAMES J. POYER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8810 WALTHER BLVD. APT. 3311 LARNEY MARYLAND 21234</b>				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>PARKWOOD CEMETERY</b>		Date <b>SEP. 2 2000</b>		20c. Location - City or Town, State <b>PARKVILLE MARYLAND</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>EVANS CHAPEL OF MEMORIES 8800 HARFORD ROAD PARKVILLE MARYLAND 21234</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Lung Cancer</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number <b>D19166</b>		29d. Date signed (Month, Day, Year) <b>SEPTEMBER 1, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DR. J. ALAN BALDWIN 10629 YORK ROAD LOCKYSSVILLE, MARYLAND 21030</b>								
31. Date filed (Month, Day, Year) <b>SEP 06 2000</b>				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



00-4974-510

CHARLES POTTER

JVV

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEMS: #23 PART 1, 27, 28A-F PER MEO 68769

Certificate of Death

Reg. No.

00 27969

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Charles E. Potter</b>				2. Date of Death Month: <b>SEPTEMBER</b> Day: <b>01</b> Year: <b>2000</b>				3. Time of Death <b>01:35 A.M.</b>						
	4a. Facility Name (If not institution, give street and number) <b>1617 RACE STREET</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>				4c. County of Death <b>N/A</b>						
Funeral Director	5. Social Security Number <b>214 56 6203</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>47</b> Yrs.		If Under 1 Year Months: Days:		If Under 24 Hrs. Hours: Min.		8. Date of Birth (Month, Day, Year) <b>July 13, 1953</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
	Usual Residence of Decedent														
10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number <b>1617 Race Street</b>						10f. Zip Code <b>21230</b>				10g. Citizen of What Country? <b>U.S.</b>					
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10th</b> College (1-4or 5+) <b>College</b>						16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Warehouseman</b>				16b. Kind of Business/Industry <b>Sheet Metal Distributor</b>					
17. Father's Name (First, Middle, Last) <b>Napoleon Potter</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Dorothy Whitehead</b>									
19a. Informant's Name/Relationship (Type, Print) <b>Charles M. Potter / Son</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>411 Laura Avenue Linthicum, Maryland 21090</b>									
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Bayview Crematory, Inc.</b>				Date <b>9/7/00</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>					
21. Signature of Funeral Service Licensee <i>[Signature]</i>						22. Name and Address of Facility <b>Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225</b>									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>NARCOTIC AND COCAINE INTOXICATION</b> a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last												Approximate Interval Between Onset and Death			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
										24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b>											
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year) <b>Found: 9-1-00</b>		28b. Time of Injury <b>Found: 1:20 A</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>UNKNOWN</b>					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>FOUND: RESIDENCE</b>						28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>1617 RACE STREET BALTIMORE, MD</b>									
29e. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.															
29b. Signature and title of certifier <i>[Signature]</i>						29c. License number <b>O.C.M.E.</b>				29d. Date signed (Month, Day, Year) <b>SEPTEMBER 01, 2000</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MARY G. RIPPKE, M.D. 111 Penn Street, Baltimore, Maryland 21201</b>															
31. Date filed (Month, Day, Year) <b>SEP 06 2000</b>				32. Registrar's Signature <i>[Signature]</i>											

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Lorann Parker

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

MEO G787 98-00 WR.

Reg. No.

00 27970

AMEND ITEMS: #23 PART I, 27, 28A-F PER

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LORANN PARKER</b>		2. Date of Death Month <b>August</b> Day <b>26</b> Year <b>2000</b>		3. Time of Death <b>03:35 P.M.</b>
	4a. Facility Name (If not institution, give street and number) <b>1014 North Broadway</b>		4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>
Funeral Director	5. Social Security Number <b>213-86-5860</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>39</b>	If Under 1 Year Months <b>0</b> Days <b>0</b>	8. Date of Birth (Month, Day, Year) <b>November 17, 1960</b>
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10. Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>none</b> 10c. City, Town or Location <b>Baltimore</b> 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced					
12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:					
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:					
14. Race - American Indian, Black, White, etc. Specify: <b>AFRICAN AMERICAN</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4or 5+) <b>none</b>					
16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Home maker</b>					
17. Father's Name (First, Middle, Last) <b>Joseph Parker</b>					
18. Mother's Name (First, Middle, Maiden Surname) <b>Mabel Dixon</b>					
19. Informant's Name/Relationship (Type, Print) <b>Akilah Renee Brown-daughter</b>					
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>652 Mosher St. Baltimore, Maryland 21217</b>					
20. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)					
20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory</b>					
20c. Location - City or Town, State <b>Catonsville, Maryland</b>					
21. Signature of Funeral Service Licensee <b>Nancy M. Wallace</b>					
22. Name and Address of Facility <b>Nancy M. Wallace Funeral Service 3405 W. Franklin St - Baltimore, Md 21229</b>					
23. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or renal failure. List only one cause on each line. <b>COCAINE INTOXICATION COMPLICATED BY PROBABLE DROWNING</b>					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Scene</b>					
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined					
28a. Date of Injury (Month, Day, Year) <b>Found: 8-26-00</b>					
28b. Time of Injury <b>Found: 2:30</b>					
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
28d. Describe how injury occurred <b>UNKNOWN</b>					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>FOUND: RESIDENCE</b>					
28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>1014 N. BROADWAY BALTIMORE, MARYLAND</b>					
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>J.A. [Signature]</b>					
29c. License number <b>O.C.M.E.</b>					
29d. Date signed (Month, Day, Year) <b>August 27, 2000</b>					
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>MARY G. RIPLEY, M.D. 111 Penn Street, Baltimore, Maryland 21201</b>					
31. Date filed (Month, Day, Year) <b>SEP 06 2000</b>					
32. Registrar's Signature <b>B. Sparks</b>					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27971

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Frank J. Raffo, Sr.

2. Date of Death  
Month Day Year

September 4 2000 1:36 am

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Baltimore VA Medical Center

4b. City, Town, or Location of Death

Baltimore, MD

4c. County of Death

Baltimore City

5. Social Security Number

213-18-7785

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

02/16/1922

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

412 Chalfonte Drive

10f. Zip Code

21228

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☒ Yes ☐ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working  
life. DO NOT use retired)

Furniture Sales Manager

16b. Kind of Business/Industry

Montgomery Wards

17. Father's Name (First, Middle, Last)

Samuel Raffo

18. Mother's Name (First, Middle, Maiden Summa)

Theresa Higgins

19a. Informant's Name/Relationship (Type, Print)

Katherine H. Raffo Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

412 Chalfonte Dr. Baltimore, MD 21228

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Parkwood Cemetery

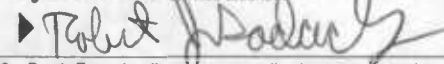
Date

09/08

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Sterling Ashton Schwab Funeral Home, Inc.  
736 Edmondson Ave. Baltimore, MD 2122823a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Abdominal Perforation

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

1 Day

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Sepsis

Chronic Lymphocytic Leukemia

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☒ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending  
investigation  
☐ Accident ☐ Suicide  
☐ Homicide ☐ Could not be  
determined

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

P13133

29d. Date signed (Month, Day, Year)

9/06/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas Liu M.D., 22 S. Greene St., Baltimore, MD 21201

31. Date filed (Month, Day, Year)

SEP 06 2000

32. Registrar's Signature

State  
Registrar

213-18-7785 FRANK RAFFO 213-18-7785

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, #25

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
permit.

10



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27972

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MARIE E REXROTH</b>				2. Date of Death Month <b>SEPT.</b> Day <b>3</b> Year <b>2000</b>		3. Time of Death <b>9:30pm</b>		
	4a. Facility Name (If not institution, give street and number) <b>220 Riverside Road</b>				4b. City, Town, or Location of Death <b>Essex</b>		4c. County of Death <b>Baltimore</b>		
Funeral Director	5. Social Security Number <b>217-05-6804</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>80</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>May 24 1920</b>		
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Essex</b>		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>220 Riverside Road</b>		10f. Zip Code <b>21221</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th</b>		College (1-4 or 5+) <b></b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Nurses Aid</b>		16b. Kind of Business/Industry <b>John Hopkins Hospital</b>			
17. Father's Name (First, Middle, Last) <b>Gustane Sturm</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Anna Trollenberg</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Franklin Rexroth / husband</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>220 Riverside Road Baltimore Md. 21221</b>					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gardens of Faith Cemetery</b>		Date <b>9/7/2000</b>		20c. Location - City or Town, State <b>Rossville MD</b>			
21. Signature of Funeral Service Licensee <b>R. Terry Connelly</b>				22. Name and Address of Facility <b>Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Alzheimer's Disease</b> Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Hypertension</b> Due to (or as a consequence of):		Approximate Interval Between Onset and Death							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension</b>				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M <b></b>	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <b>S. Milner, MD</b>		29c. License number <b>018598</b>		29d. Date signed (Month, Day, Year) <b>9/5/00</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Sheldan Milner 404 Eastern Blvd (21221)</b>				31. Date filed (Month, Day, Year) <b>SEP 06 2000</b>		32. Registrar's Signature <b>Sparks</b>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27973  
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LEO M REED			2. Date of Death Month: Sept. Day: 1 Year: 2000		3. Time of Death 21:15	
	4a. Facility Name (If not institution, give street and number) University of Maryland Medical System			4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 217-34-3602	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months: Days:	If Under 24 Hrs. Hours: Min.	8. Date of Birth (Month, Day, Year) 03-01-1914	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent						
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 30 E. Henrietta Street			10f. Zip Code 21230		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1943-45		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 12 College (1-4 or 5+): 0			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Deputy Clerk		16b. Kind of Business/Industry Superior Court of Balto. City		
17. Father's Name (First, Middle, Last) George W. Reed				18. Mother's Name (First, Middle, Maiden Surname) Ella Finn			
19a. Informant's Name/Relationship (Type, Print) William M Reed (Son)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 504 Forest Lane, Catonsville, Maryland 21228				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Mem. Park		Date 09-05-00		20c. Location - City or Town, State Elkridge, Maryland	
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 130 East Fort Avenue, Baltimore, Maryland 21230				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
Immediate Cause (Final disease or condition resulting in death)		Terminal Colon Cancer					
		Due to (or as a consequence of):					
		Metastatic Colon Cancer to liver					
		Due to (or as a consequence of):					
		Due to (or as a consequence of):					
		Due to (or as a consequence of):					
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28e. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier Warren Oberle			29c. License number P14734			29d. Date signed (Month, Day, Year) 09/06/2000	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Hamm Tadd O Baker 22 SOUTH GREENE ST. BALTO, MD 21201							
31. Date filed (Month, Day, Year) SEP 06 2000		32. Registrar's Signature 					

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **00 27974**  
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Arthur E. Redman</b>				2. Date of Death Month <b>September</b> Day <b>4</b> , Year <b>2000</b>		3. Time of Death <b>11:00 am</b>	
	4a. Facility Name (If not institution, give street and number) <b>Good Samaritan Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death	
Funeral Director	5. Social Security Number <b>212-40-6250</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>59</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>April 10, 1941</b>	
	9. Birthplace (State or Foreign Country) <b>MD</b>		10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Baltimore</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number <b>3008 Ruekert Avenue 1st Fl.</b>		10f. Zip Code <b>21214</b>	
	10g. Citizen of What Country? <b>U.S.A.</b>				11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>College (1-4 or 5+)</b>	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Furniture mover</b>				16b. Kind of Business/Industry <b>Moving &amp; storage</b>		17. Father's Name (First, Middle, Last) <b>Arthur Edward Redman</b>	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) <b>Viola</b>				19a. Informant's Name/Relationship (Type, Print) <b>Joan M. Redman- Wife</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3008 Ruekert Ave., 1st Fl., Baltimore, MD 21214</b>	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Parkwood Cemetery</b>		20c. Location - City or Town, State <b>9/7/00 Baltimore, MD</b>	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <b>William G. Dau</b>				22. Name and Address of Facility <b>Leonard J. Ruck Funeral Home, Inc. 5305 Harford Road, Baltimore, MD 21214</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  <b>a. Cardio-pulmonary arrest</b> Due to (or as a consequence of): <b>b. Cardiac arrhythmia</b> Due to (or as a consequence of): <b>c. Coronary heart disease</b> Due to (or as a consequence of): <b>d.</b>				Approximate Interval Between Onset and Death <b>1 hr.</b> <b>yr.</b>			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic obstructive pulmonary disease</b> <b>- Pulmonary Fibrosis</b> <b>- Respiratory failure (on Nasal O<sub>2</sub>)</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year) <b>28b. Time of Injury</b> <b>28c. Injury at Work?</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>28d. Describe how injury occurred</b> <b>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</b> <b>28f. Location (Street and Number or Rural Route Number, City or Town, State)</b>			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <b>md.</b>			
	29c. License number <b>D-17992</b>				29d. Date signed (Month, Day, Year) <b>9/5/00</b>			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>KHAN M. TUN 1312 Goucher Blvd Towson md 21286</b>				31. Date filed (Month, Day, Year) <b>SEP 06 2000</b>			
	32. Registrar's Signature <b>APR</b>				33. Registrar's Signature <b>APR</b>			



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State of Maryland / Department of Health and Mental Hygiene

00 27975

Amended Item #1 per PHYG787 9/13/2000 EW

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <del>Rockstroh</del> John Raymond Rockstroh				2. Date of Death Month Day Year 09 02 2000		3. Time of Death 12:45 PM	
	4a. Facility Name (If not institution, give street and number) 3117 Hayfield Drive				4b. City, Town, or Location of Death Ellicott City		4c. County of Death Howard	
Funeral Director	5. Social Security Number 212-28-8004		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 69 Yrs.		8. Date of Birth (Month, Day, Year) 12/27/1930	
	9. Birthplace (State or Foreign Country) MD		10a. State MD		10b. County Howard		10c. City, Town or Location Ellicott City	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 3117 Hayfield Drive		10f. Zip Code 21042		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) computer programmer		16b. Kind of Business/Industry NSA				
17. Father's Name (First, Middle, Last) Thomas J. Rockstroh				18. Mother's Name (First, Middle, Maiden Surname) Anna C. Dietrick				
19a. Informant's Name/Relationship (Type, Print) Paul M. Rockstroh - son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4711 Poole Road, Sykesville, Md. 21784				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Crestlawn Memorial Gardens		20c. Location - City or Town, State Marriottsville, Md.		20d. Date 9/6/2000		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Witzke Funeral Home of Catonsville, 1630 Edmondson Avenue, Catonsville, Maryland 21228				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Myocardial Infarction Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Attending Physician		29c. License number D30631		29d. Date signed (Month, Day, Year) 09/03/00				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. ALAN REISINGER III MD, 700 Geipe Rd Catonsville MD 21228								
31. Date filed (Month, Day, Year) SEP 06 2000		32. Registrar's Signature 						

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

27976

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>DOROTHY RUBY</b>		2. Date of Death Month <b>SEPTEMBER</b> Day <b>01</b> Year <b>2000</b>		3. Time of Death <b>6:20 PM</b>
	4a. Facility Name (If not institution, give street and number) <b>The Johns Hopkins Hospital Baltimore</b>		4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death
Funeral Director	5. Social Security Number <b>216-10-1465</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>82</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>4-23-1918</b>		9. Birthplace (State or Foreign Country) <b>MD.</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State <b>MD</b>		10b. County <b>County</b>
	10c. City, Town or Location <b>Ellicott City</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>10297 Wetherburn Road</b>		10f. Zip Code <b>21042</b>		10g. Citizen of What Country? <b>USA</b>
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Printer</b>
	16b. Kind of Business/Industry <b>City of Los Angeles</b>		17. Father's Name (First, Middle, Last) <b>Carroll I. Waltz</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Margaret V. Frizzell</b>
	19a. Informant's Name/Relationship (Type, Print) <b>Guy G. Mancini, Jr. - son</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10297 Wetherburn Road, Ellicott City, Md. 21042</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Crestlawn Memorial Cemetery</b>		20c. Location - City or Town, State <b>9/6/2000 Marriottsville, Md.</b>
	21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <b>Witzke Funeral Homes, Inc. 1630 Edmondson Avenue, Catonsville, Md. 21228</b>		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		a. <b>MASSIVE MESENTERIC INFARCTION</b> Due to (or as a consequence of):		Approximate Interval Between Onset and Death <b>2 days</b>
b. <b>ACUTE RENAL FAILURE</b> Due to (or as a consequence of):		c. <b>CARDIOVASCULAR FAILURE</b> Due to (or as a consequence of):		<b>2 days</b>	
d.					
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
	29b. Signature and title of certifier <i>Keith Lee DO.</i>		29c. License number <b>RESIDENT P8601</b>		29d. Date signed (Month, Day, Year) <b>SEPTEMBER 01, 2000</b>
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>KEITH LEE 600 NORTH WOLFE STREET, BALTIMORE, MD 21287-9106</b>				
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 06 2000</b>		32. Registrar's Signature <i>[Signature]</i>		

ORIGINAL

5-28-1964

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State of Maryland / Department of Health and Mental Hygiene 00 27977

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Christine Smith</i>				2. Date of Death Month <i>September</i> Day <i>3</i> Year <i>2000</i>				3. Time of Death <i>3:35 am</i>						
	4a. Facility Name (If not institution, give street and number) <i>Skila Morris @ Mercy</i>				4b. City, Town, or Location of Death <i>Baltimore</i>				4c. County of Death <i>NA</i>						
Funeral Director	5. Social Security Number <i>219-40-4193</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>57</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>November 15, 1942</i>		9. Birthplace (State or Foreign Country) <i>MD</i>						
	Usual Residence of Decedent				10a. State <i>MD</i>				10b. County <i>NA</i>		10c. City, Town or Location <i>Baltimore</i>				
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number <i>2904 Presstman St.</i>				10f. Zip Code <i>21216</i>		10g. Citizen of What Country? <i>USA</i>				
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <i>African American</i>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12th</i> College (1-4or 5+) <i>0</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Domestic</i>				16b. Kind of Business/Industry <i>Homes</i>						
	17. Father's Name (First, Middle, Last) <i>Leon Fountain Sr.</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Thelen Anthony</i>										
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <i>Thomas Smith Spouse</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2904 Presstman St. Baltimore, MD 21216</i>										
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Garrison Forest Ceterm.</i>				20c. Location - City or Town, State <i>Quiring Mill, MD</i>						
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <i>Wynn Funeral Home PA 638 N. Summit St. Baltimore, MD 21217</i>										
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <i>Metastatic breast cancer</i> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):				Approximate Interval Between Onset and Death										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <i>hospice</i>											
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred					
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <i>D40854</i>		29d. Date signed (Month, Day, Year) <i>9/5/2000</i>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>David Rosenberg 301 St Paul Pl Baltimore 21202</i>															
31. Date filed (Month, Day, Year) <i>SEP 06 2000</i>				32. Registrar's Signature <i>[Signature]</i>											

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 0002.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

00 27978

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Victor Eugene Seckens				2. Date of Death Month: 09 Day: 02 Year: 2000		3. Time of Death 11:30 am	
	4a. Facility Name (If not institution, give street and number) 18 Liberty Parkway				4b. City, Town, or Location of Death Dundalk		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 217-24-4069		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 70 Yrs.		8. Date of Birth (Month, Day, Year) 03/27/1930	
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County Baltimore		10c. City, Town or Location Dundalk	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 18 Liberty Parkway		10f. Zip Code 21222	
	10g. Citizen of What Country? United States				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Brakeman				16b. Kind of Business/Industry Railroad		17. Father's Name (First, Middle, Last) Andrew Seckens	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) Louise McDonald				19a. Informant's Name/Relationship (Type, Print) Margaret Seckens Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18 Liberty Parkway, Dundalk MD 21222	
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Sacred Heart of Jesus Cem		20c. Location - City or Town, State 9/6/00 Baltimore, Maryland	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Bradley-Ashton-Matthews Funeral Home, Inc. 2134 Willow Spring Road, Dundalk MD 21222			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>metastatic Prostate Cancer</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death 2 1/2 yrs			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred			
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier  M.D.			
To Be Completed by Physician/Medical Examiner	29c. License number D 45390				29d. Date signed (Month, Day, Year) 9/5/00			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) myo mcn (M.D.) 6830 HOSPITAL DR. # 206, BALTIMORE, MD 21237				31. Date filed (Month, Day, Year) SEP 06 2000			
To Be Completed by Physician/Medical Examiner	32. Registrar's Signature 				33. Date of Death SEP 06 2000			
	34. Registrar's Title Registrar				35. Registrar's Signature 			

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27979

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Minnie Shilling</i>		2. Date of Death Month <i>9</i> Day <i>1</i> Year <i>00</i>		3. Time of Death <i>4:00 AM</i>	
	4a. Facility Name (If not institution, give street and number) <i>Gilchrist Cener</i>		4b. City, Town, or Location of Death <i>Towson</i>		4c. County of Death <i>Baltimore</i>	
Funeral Director	5. Social Security Number <i>239-22-8205</i>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>76 Yrs.</i>	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>Feb 24, 1924</i>
	9. Birthplace (State or Foreign Country) <i>North</i>					
Usual Residence of Decedent						
10a. State <i>MD</i>		10b. County <i>Baltimore</i>		10c. City, Town or Location <i>Towson</i>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number <i>8 Acorn Circle Apt. 201</i>			10f. Zip Code <i>21286</i>		10g. Citizen of What Country? <i>U.S.A.</i>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>White</i>
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>College</i>			16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Operator</i>		16b. Kind of Business/Industry <i>C&amp;P Telephone</i>	
17. Father's Name (First, Middle, Last) <i>Hinton Cole Lewis</i>			18. Mother's Name (First, Middle, Maiden Surname) <i>Minnie Lee Gregory</i>			
19a. Informant's Name/Relationship (Type, Print) <i>Linda Cortez-Friend</i>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>21 Acorn Circle # 103, Towson, MD 21286</i>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Evans Funeral Chapel-Bel Air</i>		Date <i>Sep 3 2000</i>	20c. Location - City or Town, State <i>Forest Hill, MD</i>	
21. Signature of Funeral Service Licensee <i>[Signature]</i>			22. Name and Address of Facility <i>Evans Funeral Chapel 8800 Harford Rd. Parkville, MD</i>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <i>a. Cardiopulmonary Arrest</i> <i>b. Metastatic Renal Cell Carcinoma</i>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <i>c.</i> <i>d.</i>						Approximate Interval Between Onset and Death <i>30 min.</i>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Coronary Artery Disease Hyperlipidemia</i> <i>Hypertension</i> <i>Breast Cancer</i>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <i>Hospice</i>				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	28b. Time of Injury <i>M</i>	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred	
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
29b. Signature and title of certifier <i>William D. McConnell MD</i>			29c. License number <i>D 42129</i>		29d. Date signed (Month, Day, Year) <i>9-1-00</i>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>William D. McConnell MD 500 W. University Baltimore MD</i>						
31. Date filed (Month, Day, Year) <i>SEP 06 2000</i>		32. Registrar's Signature <i>[Signature]</i>				

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

00 27980

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HELEN J SQUILLER</b>		2. Date of Death Month Day Year <b>SEPT. 3, 2000</b>		3. Time of Death <b>1310 PM</b>
	4a. Facility Name (If not institution, give street and number) <b>3939 ROLAND AVENUE APT.#214</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>
Funeral Director	5. Social Security Number <b>337262419</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>72</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>MARCH 22 1928</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
Usual Residence of Decedent					
10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Baltimore</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <b>3939 Roland Ave.</b>			10f. Zip Code <b>21211</b>		10g. Citizen of What Country? <b>USA</b>
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Waitress</b>		16b. Kind of Business/Industry <b>Resteraunt</b>	
17. Father's Name (First, Middle, Last) <b>James Vincent Lupo Sr.</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Lucille Hanna</b>		
19a. Informant's Name/Relationship (Type, Print) <b>James V. Lupo Jr. / brother</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7373 Edsworth Road Baltimore Md. 21222</b>		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory Inc.</b>		20c. Location - City or Town, State <b>Baltimore Md.</b>	
21. Signature of Funeral Service Licensee <b>R. Terry Connelly</b>		22. Name and Address of Facility <b>Connelly Funeral Home of Essex 300 Mace Ave. Baltimore MD 21221</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>a. Hypertensive atherosclerotic Cardiovascular disease</b> Due to (or as a consequence of):					Approximate Interval Between Onset and Death
b. Due to (or as a consequence of):					
c. Due to (or as a consequence of):					
d. Due to (or as a consequence of):					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
					24a. Was an autopsy performed? <b>Inspection</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>AT SCENE</b>			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>Stephen S. Radentz, M.D.</b>		29c. License number <b>O.C.M.E</b>		29d. Date signed (Month, Day, Year) <b>SEPT. 4, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201</b>					
31. Date filed (Month, Day, Year) <b>SEP 06 2000</b>		32. Registrar's Signature <b>Benjamin B. Sparks</b>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



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State of Maryland / Department of Health and Mental Hygiene

00 27981

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JAMES STEWART</b>				2. Date of Death Month Day Year <b>AUGUST 31 2000</b>		3. Time of Death <b>7:16 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>GOOD SAMARITAN HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>NA</b>	
Funeral Director	5. Social Security Number <b>214-62-9309</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>47</b>		8. Date of Birth (Month, Day, Year) <b>05-13-53</b>	
	Usual Residence of Decedent		9. Birthplace (State or Foreign Country) <b>MD</b>		10a. State <b>MD</b>		10b. County <b>NA</b>	
10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>2319 Robb Street</b>		10f. Zip Code <b>21218</b>		
10g. Citizen of What Country? <b>USA</b>		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		
14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th Grade</b> College (1-4 or 5+) <b>NA</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>General Baker</b>		16b. Kind of Business/Industry <b>A&amp;P Bakery Company</b>		
17. Father's Name (First, Middle, Last) <b>James Stewart</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mildred Jones</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Mildred Stewart</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2319 Robb Street Baltimore, Maryland 21218</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>King Mem. Pk. Cem.</b>		20c. Date <b>09-08-2000</b>		20d. Location - City or Town, State <b>Randallstown, MD</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Baltimore, Maryland 21202</b> <b>WM.C. March FH 1101 E. North Avenue</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>MYOCARD INFARCTION</b>								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier  M.D.				29c. License number <b>P 12555</b>		29d. Date signed (Month, Day, Year) <b>AUGUST, 31, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>RAMIN ALTAHA, M.D. 5601 LOCH RAVEN BLVD. BALTIMORE, MD 21236</b>								
31. Date filed (Month, Day, Year) <b>SEP 06 2000</b>				32. Registrar's Signature 				





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State of Maryland / Department of Health and Mental Hygiene

00 27982

AMEND ITEMS: #23 PART I, 27 PER MEO G787 <sup>9-13-00 WP</sup> Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Johanna F. Sears</b>				2. Date of Death Month Day Year <b>AUGUST 29 2000</b>				3. Time of Death <b>15:05 PM</b>						
	4a. Facility Name (If not institution, give street and number) <b>2304 MASSANUTTEN DRIVE</b>				4b. City, Town, or Location of Death <b>SILVER SPRING</b>				4c. County of Death <b>MONTGOMERY</b>						
Funeral Director	5. Social Security Number <b>091-36-9855</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>57</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) <b>06 04 1943</b>		9. Birthplace (State or Foreign Country) <b>NY</b>		
	Usual Residence of Decedent														
10a. State <b>MD</b>				10b. County <b>Montgomery</b>				10c. City, Town or Location <b>Silver Springs</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number <b>2304 Massanutten Drive</b>						10f. Zip Code <b>20906</b>				10g. Citizen of What Country? <b>USA</b>					
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>5+</b>						16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Research Assistant</b>				16b. Kind of Business/Industry <b>US Government</b>					
17. Father's Name (First, Middle, Last) <b>Francisco Collura</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Cleo Virginia Zimmer</b>									
19a. Informant's Name/Relationship (Type, Print) <b>Paul Sears/ Brother</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8890 Boak Road Holland Patent, NY 13354</b>									
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Chesapeake Crematory</b>				Data <b>9-2-00</b>		20c. Location - City or Town, State <b>Beltsville, Md.</b>					
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility <b>Sterling-Ashton-Schwab Funeral Home, Inc 736 Edmondson Avenue, Baltimore, Md. 21228</b>									
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>DILATED CARDIOMYOPATHY</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>ALCOHOLISM; LIVER STEATOSIS</b>										Approximate Interval Between Onset and Death				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ALCOHOLISM; LIVER STEATOSIS</b>										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No											
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b>											
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred					
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29e. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. Signature and title of certifier  <b>Stephen S. Radentz, M.D.</b>						29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>AUGUST 30, 2000</b>							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201</b>															
31. Date filed (Month, Day, Year) <b>SEP 06 2000</b>				32. Registrar's Signature 											

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27983

AMENDED ITEM #19b PER FH G787 9/6/00 AH

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Blanche Shelton</b>		2. Date of Death Month <b>August</b> Day <b>30</b> Year <b>2000</b>		3. Time of Death <b>4:00pm</b>
	4a. Facility Name (If not institution, give street and number) <b>Stella Maris Towson</b>		4b. City, Town, or Location of Death <b>Towson</b>		4c. County of Death <b>Baltimore</b>
Funeral Director	5. Social Security Number <b>213-16-6753</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>87</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>07 09 13</b>		9. Birthplace (State or Foreign Country) <b>S.C.</b>		
Usual Residence of Decedent					
10a. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number <b>3468 Dolfield Ave</b>		10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th grade</b> College (1-4 or 5+) <b>na</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Nursing</b>		16b. Kind of Business/Industry <b>Private Duty</b>	
17. Father's Name (First, Middle, Last) <b>Curtis Simpson</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Cattie C. Simpson</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Timothy Shelton Sr.- Son</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3468 Dolfield Ave, Baltimore Md 21215</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arbutus Memorial Park</b>		20c. Location - City or Town, State <b>9/5/00 Arbutus, Md</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>March F/H West</b> <b>4300 Wabash Ave, Baltimore Md 21215</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Renal Failure</b> Due to (or as a consequence of): <b>Diabetes mellitus</b> Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>HOSPICE</b>					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number <b>D43725</b>		29d. Date signed (Month, Day, Year) <b>9/1/00</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093</b>					
31. Date filed (Month, Day, Year) <b>SEP 06 2000</b>		32. Registrar's Signature 			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

AUGUST 30, 2000 4:10 p.m.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

BLANCHE SHELTON

MOLATE



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State of Maryland / Department of Health and Mental Hygiene 00 27984

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>PHYLLIS ANN SMITH</b>				2. Date of Death Month Day Year <b>SEPTEMBER 3, 2000</b>		3. Time of Death <b>3:45AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>HARBOR HOSPITAL CENTER 3001 SOUTH HANOVER STREET</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death	
Funeral Director	5. Social Security Number <b>212-44-1363</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (in yrs. last birthday) <b>55</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>07 17 45</b>	
	Usual Residence of Decedent		9. Birthplace (State or Foreign Country) <b>D.C.</b>		10. State <b>MD</b>		10b. County <b>NA</b>	
10a. State		10b. County		10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>2425 Dorton Court</b>		10f. Zip Code <b>21230</b>		10g. Citizen of What Country? <b>U.S.A.</b>				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11th grade</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Home</b>				
17. Father's Name (First, Middle, Last) <b>Roosevelt Hawkins</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Louise Pope</b>		19a. Informant's Name/Relationship (Type, Print) <b>Charles L. Smith Sr. Husband</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2425 Dorton Ct, Baltimore Md 21230</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arbutus Memorial Park</b>		20c. Location - City or Town, State <b>9/8/2000 Arbutus, Md</b>				
21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <b>March F/H West 4300 Wabash Ave, Baltimore Md 21215</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>a. UPPER GASTROINTESTINAL HEMORRHAGE (7) HOURS</b> Due to (or as a consequence of): <b>b. COLON CANCER, STAGE FOUR (1) YEAR</b> Due to (or as a consequence of): <b>c. LIVER METASTASIS (1) YEAR</b> Due to (or as a consequence of): <b>d.</b>		Approximate Interval Between Onset and Death		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		
27. Manner of Death		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28a. Date of Injury (Month, Day, Year)		28b. Time of Injury		28c. Injury at Work?		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>FIRST YEAR RESIDENT</b>		
29a. Certifier (Check only one)		29c. License number <b>P13470</b>		29d. Date signed (Month, Day, Year) <b>SEPTEMBER 3, 2000</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>HARBOR HOSPITAL CENTER 3001 SOUTH HANOVER STREET, BALTIMORE, MD 21225</b>		
31. Date filed (Month, Day, Year) <b>SEP 06 2000</b>		32. Registrar's Signature <i>[Signature]</i>		33. Registrar's Name <b>MOHAMMED ALI TARRIM</b>				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

DHHM 16 Rev 6/95

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JAN 12 1962  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.

TO: DIRECTOR, AGRICULTURAL RESEARCH  
SERVICE  
FROM: [illegible]  
SUBJECT: [illegible]

RECEIVED  
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U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27985

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MARY ELIZABETH SIMPKINS</b>				2. Date of Death Month Day Year <b>AUG 27 2000</b>		3. Time of Death <b>9:20PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>5216 CATALPHA ROAD</b>				4b. City, Town, or Location of Death <b>HAMILTON</b>		4c. County of Death <b>—</b>	
Funeral Director	5. Social Security Number <b>215-34-7724</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>63</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>DEC 17, 1936</b>	
	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>		10a. State <b>MD</b>		10b. County <b>—</b>		10c. City, Town or Location <b>HAMILTON</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>5216 CATALPHA ROAD</b>		10f. Zip Code <b>21214</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOMEMAKER</b>		16b. Kind of Business/Industry <b>DOMESTIC</b>		17. Father's Name (First, Middle, Last) <b>JEROME F. CARTER</b>		
18. Mother's Name (First, Middle, Maiden Surname) <b>BEATRICE KING</b>		19a. Informant's Name/Relationship (Type, Print) <b>ROBERT SIMPKINS, SON</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6601 WALTER AVE # 2-A OVERLEA, MD 21206</b>		20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		
20b. Place of Disposition (Name of cemetery, crematory or other place) <b>PROSPECT HILL CEMETERY</b>		20c. Date <b>AUG 30 2000</b>		20d. Location - City or Town, State <b>TOWSON, MD</b>		21. Signature of Funeral Service Licensee 		
22. Name and Address of Facility <b>EVANS FUNERAL CHAPEL</b>		22b. Address <b>3800 HARFORD RD. PARKVILLE, MD 21234</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>a. Myocardial infarction</b> Due to (or as a consequence of): <b>b. Coronary Artery Disease</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>		Approximate interval Between Onset and Death		
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year) <b>28b. Time of injury</b> <b>28c. Injury at Work?</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		
29c. License number <b>D21242</b>		29d. Date signed (Month, Day, Year) <b>August 29, 2000</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>GREGORY KELLY, MD. 4924 CAMPBELL BLVD STE 200 WHITEMARSH, MD 21236</b>		31. Date filed (Month, Day, Year) <b>SEP 06 2000</b>		
32. Registrar's Signature 		33. State Registrar <b>SEP 06 2000</b>		34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020		35. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.		

ORIGINAL

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✓

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27986

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Bessie Lee Smith

2. Date of Death

September 1, 2000

3. Time of Death

7:30 AM

4a. Facility Name (If not institution, give street and number)

Milford Manor Nursing Home

4b. City, Town, or Location of Death

Pikesville

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

216-14-8036

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
09/09/1909

9. Birthplace (State or Foreign Country)

Georgia

Usual Residence of Decedent

10a. State

Maryland

10b. County

10c. City, Town or Location

Pikesville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7206 Valley Country Court # A3

10f. Zip Code

21208

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
9

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Cook

16b. Kind of Business/Industry

Food Industry

17. Father's Name (First, Middle, Last)

Bill Yancey

18. Mother's Name (First, Middle, Maiden Surname)

Leona Glen

19a. Informant's Name/Relationship (Type, Print)

Addie Lee Davis / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7206 Valley Country Court # A3, Pikesville, Md. 21208

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

King Memorial Pk. Ceme.

Date

09/08/00

20c. Location - City or Town, State

Woodlawn, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Derrick C. Jones Funeral Home

4611 Park Heights Ave., Baltimore, Maryland 21215

23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cerebral Vascular Accident

Approximate Interval Between Onset and Death

2 months

Due to (or as a consequence of):

b. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

gangrene Foot

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D27034

29d. Date signed (Month, Day, Year)

September 1, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Trautman Copeland 1838 Greene Tree Rd Pikesville MD 21208

31. Date filed (Month, Day, Year)

SEP 06 2000

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

A14



jhm  
vincent

smith AMEND

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27987

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Vincent L. Smith

2. Date of Death

Month Day Year  
SEPTEMBER 01, 2000

3. Time of Death

05:00 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

4434 LAPLATA AVENUE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

U.S.A.

5. Social Security Number

219-74-7699

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

38

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
5-25-1962

9. Birthplace (State or Foreign Country)

Md.

Usual Residence of Decedent

10a. State  
Md.10b. County  
N/A10c. City, Town or Location  
Baltimore10d. Inside City Limits  
1 ☒ Yes 2 ☐ No

10e. Street and Number

4434 Laplata Ave.

10f. Zip Code

21211

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No  
If Yes, Give Year or Dates: 1981-1984

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (9-12)  
12th grade

College (1-4or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Labox

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Luke Smith

18. Mother's Name (First, Middle, Maiden Surname)

Jackqueline Smith

19a. Informant's Name/Relationship (Type, Print)

Ruth Smith

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13 Vanyereall Ct. Balto. Md. 21207

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GARRISON FOREST CEM. / and Owen Mills Md.

Date

9/8/2000

20c. Location - City or Town, State

Baltimore Md.

21. Signature of Funeral Service Licensee

► Reverend Christopher

22. Name and Address of Facility

BETHS FUNERAL HOME 21213  
1129 N. CAROLINE STREET Balto. Md

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

PNEUMONIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

ACQUIRED IMMUNO-DEFFICIENCY SYNDROME

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) SCENE

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician2 ☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

► Dennis Chute

29c. License number

OCME

29d. Date signed (Month, Day, Year)

SEPTEMBER 01, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dennis Chute

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

SEP 06 2000

32. Registrar's Signature

► Benita Sparks

State  
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27988

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CAROLYN LEE SWARTZ				2. Date of Death Month Day Year AUGUST 23, 2000		3. Time of Death 9:00am	
	4a. Facility Name (If not institution, give street and number) 3138 JEFFREY ROAD				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 218-40-0198		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 57 Yrs.		8. Date of Birth (Month, Day, Year) OCT. 20, 1942	
	9. Birthplace (State or Foreign Country) MARYLAND		10a. State MARYLAND		10b. County BALTIMORE		10c. City, Town or Location BALTIMORE	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 3138 JEFFREY ROAD		10f. Zip Code 21244		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) VOLUNTEER AID		16b. Kind of Business/Industry CHURCH		17. Father's Name (First, Middle, Last) BERNARD EUGENE CAMPBELL	
	18. Mother's Name (First, Middle, Maiden Surname) MARY IDA O'NIELL		19a. Informant's Name/Relationship (Type, Print) CHERYLL A. PRODOEHL (DAUGHTER)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2947 BLOOM RD., FINKSBURG, MD 21048		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) LOUDON PARK CEMETERY		20c. Location - City or Town, State BALTIMORE, MARYLAND		21. Signature of Funeral Service Licensee [Signature]		22. Name and Address of Facility LOUDON PARK FUNERAL HOME 3620 WILKINS AVE., BALTIMORE, MD 21229	
	23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) END STAGE COPD Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):		23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	
	28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier [Signature: Howard Jacobs, MD]		29c. License number D 28792		29d. Date signed (Month, Day, Year) AUGUST 24, 2000	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) HOWARD JACOBS, M.D., 20 CROSSROADS DR. #14, OWINGS MILLS, MD. 21117		31. Date filed (Month, Day, Year) SEP 06 2000		32. Registrar's Signature [Signature]		33. State Registrar SEP 06 2000	

ORIGINAL



JOAN SCHRUEFER

State of Maryland / Department of Health and Mental Hygiene

PER. MEO G487 9-8-00 WR.

00 27989

ASP AMEND ITEMS: #23 PART I, 27, 28A-F Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Joan Alice Schrufer</b>				2. Date of Death Month Day Year <b>AUGUST 30 2000</b>				3. Time of Death <b>10:30 A</b>		
	4a. Facility Name (If not institution, give street and number) <b>1218 TEN OAKS RD.</b>				4b. City, Town, or Location of Death <b>Arbutus</b>				4c. County of Death <b>BALTIMORE</b>		
Funeral Director	5. Social Security Number <b>220-72-4131</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>41</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>May 23, 1959</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
	Usual Residence of Decedent				10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Arbutus</b>		
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number <b>1218 Ten Oaks Road</b>				10f. Zip Code <b>21227</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Maintenance Worker</b>				16b. Kind of Business/Industry <b>Apartment Complex</b>			
17. Father's Name (First, Middle, Last) <b>Fred H. Schrufer</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Joan M. Swartz</b>							
19a. Informant's Name/Relationship (Type, Print) <b>Fred H. Schrufer-Father</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1218 Ten Oaks Road, Arbutus, Maryland 21227</b>							
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Fort Lincoln Crematory</b>				Date <b>9-1-00</b>		20c. Location - City or Town, State <b>Brentwood, Maryland</b>	
21. Signature of Funeral Service Licensee <i>Luis S. Jefferson</i>				22. Name and Address of Facility <b>Loudon Park Funeral Home 3620 Wilkens Avenue, Baltimore, Maryland 21229</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>OXYCODONE INTOXICATION</b>				a. Due to (or as a consequence of):				Approximate Interval Between Onset and Death			
b. Due to (or as a consequence of):				c. Due to (or as a consequence of):				d. Due to (or as a consequence of):			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify)							
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year) <b>8-30-00</b>		28b. Time of Injury <b>UNKNOWN</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>SUBJECT INGESTED DRUG</b>	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>HOME</b>				28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>1218 TEN OAKS RD. BALTIMORE CO., MD.</b>							
29a. Certify (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <b>O.C.M.E</b>		29d. Date signed (Month, Day, Year) <b>AUGUST 31, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>[Signature]</i> <b>111 Penn Street, Baltimore, Maryland 21201</b>											
31. Date filed (Month, Day, Year) <b>SEP 06 2000</b>				32. Registrar's Signature <i>[Signature]</i>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27990

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Charles Harry Stevens</b>				2. Date of Death Month <b>AUGUST</b> Day <b>29</b> Year <b>2000</b>				3. Time of Death <b>17:37 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>1323 CHURCH STREET</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>				4c. County of Death <b>N/A</b>		
Funeral Director	5. Social Security Number <b>220 20 3225</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>71</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>May 25, 1929</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
	Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>N/A</b> 10c. City, Town or Location <b>Baltimore</b> 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number <b>1323 Church Street</b>				10f. Zip Code <b>21226</b>		10g. Citizen of What Country? <b>U.S.</b>
To Be Completed by Funeral Director		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates <b>Korean</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th</b> College (1-4or 5+) <b>Long Shoreman</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Dundalk Marine Terminal</b>				16b. Kind of Business/Industry			
To Be Completed by Physician/Medical Examiner		17. Father's Name (First, Middle, Last) <b>Charles Joseph Stevens</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Elizabeth Moody</b>					
		19a. Informant's Name/Relationship (Type, Print) <b>Naomi Stevens / Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>909 Light Street Baltimore, Maryland 21230</b>					
To Be Completed by Physician/Medical Examiner		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MD. State Veteran Cem.</b>		Date <b>9/1/00</b>		20c. Location - City or Town, State <b>Crownsville, Maryland</b>			
		21. Signature of Funeral Service Licensee <i>Sharon M. Myer</i>		22. Name and Address of Facility <b>Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225</b>							
To Be Completed by Physician/Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>a. Atherosclerotic Cardiovascular disease complicated Due to (or as a consequence of): by ruptured aortic aneurysm</b>								Approximate Interval Between Onset and Death	
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>									
To Be Completed by Physician/Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b>							
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
To Be Completed by Physician/Medical Examiner				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
		29b. Signature and title of certifier <i>Atysha A. Mack, M.D.</i>				29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>AUGUST 30, 2000</b>			
To Be Completed by Physician/Medical Examiner		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201</b>									
		31. Date filed (Month, Day, Year) <b>EP 0 6 2000</b>		32. Registrar's Signature <i>Benjamin J. Sparks</i>							





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27991

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Gloria Snyder</b>				2. Date of Death Month <b>August</b> Day <b>29</b> Year <b>2000</b>				3. Time of Death <b>11:45 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Lorien Columbia Nursing &amp; Rehabilitation</b>				4b. City, Town, or Location of Death <b>Columbia</b>				4c. County of Death <b>Howard</b>	
Funeral Director	5. Social Security Number <b>217 24 2130</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>70</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Nov. 3, 1929</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Howard</b>		10c. City, Town or Location <b>Columbia</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>6334 Cedar Lane</b>				10f. Zip Code <b>21044</b>		10g. Citizen of What Country? <b>U.S.</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b>		College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>Own Home</b>		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Edward Hoffman</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Hilma Johnson</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Donna Schline / Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>130 Chesapeake Estate Drive Stevensville, MD 21666</b>					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Hilltop Service Corp.</b>		Date <b>8/31/00</b>		20c. Location - City or Town, State <b>Towson, Maryland</b>			
	21. Signature of Funeral Service Licensee <i>Sharon Sumner</i>				22. Name and Address of Facility <b>Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225</b>					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>Immediate Cause (Final disease or condition resulting in death)</b> <b>Congestive heart failure</b> Due to (or as a consequence of):  <b>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</b> a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death <b>3 weeks</b>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
									24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
State Registrar	29b. Signature and title of certifier <i>Bruce M. Conner</i> <b>Interim</b>				29c. License number <b>D32013</b>		29d. Date signed (Month, Day, Year) <b>August 30, 2000</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Bruce M. Conner 205, 11055 Little Patuxent Parkway MD 20642</b>									
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 06 2000</b>				32. Registrar's Signature <i>Benjamin Sparks</i>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at 410-326-6000.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 27992

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Philip T

2. Date of Death

Month Day Year  
August 28, 2000

3. Time of Death

8:35 PM

4a. Facility Name (If not institution, give street and number)

Baltimore Rehabilitation and Extended Care

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

220 36 6798

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

59

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 11, 1941

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

18 Mapledale Avenue

10f. Zip Code

21061

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: Viet Nam

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2 years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Field Service Engineer

16b. Kind of Business/Industry

Hospital Equipment

17. Father's Name (First, Middle, Last)

Charles Davis Solloway

18. Mother's Name (First, Middle, Maiden Surname)

Clara Marie Potter

19a. Informant's Name/Relationship (Type, Print)

Bernice Solloway / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

18 Mapledale Avenue Glen Burnie, Maryland 21061

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Md. Veteran Cemetery

Date

8/31/00

20c. Location - City or Town, State

Crownsville, Maryland

21. Signature of Funeral Service Licensee

Dorothy Bromisowski

22. Name and Address of Facility

Gonce Funeral Home P.A.  
4001 Ritchie Highway Baltimore, Md. 21225

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Dementia, Alzheimers type

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

8 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Perry L. Colvin MD

29c. License number

D0032548

29d. Date signed (Month, Day, Year)

August 28, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Perry L. Colvin MD

10 North Greene Street  
Baltimore, MarylandState  
Registrar

31. Date filed (Month, Day, Year)

SEP 06 2000

32. Registrar's Signature

Perry L. Colvin

ORIGINAL

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27993

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) OSTAP SADOWYJ				2. Date of Death Month Day Year SEPT. 1, 2000		3. Time of Death 9:15 a.m.	
	4a. Facility Name (If not institution, give street and number) 3708 STANSBURY MILL ROAD				4b. City, Town, or Location of Death PHOENIX		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 212-32-6151		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 76 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 14, 1924	
	9. Birthplace (State or Foreign Country) UKRAINE		10a. State MD.		10b. County BALTIMORE		10c. City, Town or Location PHOENIX	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 3708 STANSBURY MILL ROAD		10f. Zip Code 21131	
	10g. Citizen of What Country? U.S.A.				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: WHITE		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MACHINE OPERATOR				16b. Kind of Business/Industry BREWING CO.		17. Father's Name (First, Middle, Last) UNKNOWN	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) UNKNOWN				19a. Informant's Name/Relationship (Type, Print) MYRON SADOWYJ / SON		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3708 STANSBURY MILL ROAD, PHOENIX, MARYLAND 21131	
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) PARKWOOD CEMETERY		20c. Location - City or Town, State BALTIMORE, MARYLAND	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee LILLY & ZEILER INC. FUNERAL HOME				22. Name and Address of Facility 1901 EASTERN AVENUE, BALTIMORE, MARYLAND 21221		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Large Cell Lymphoma of Lung 2 years Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):	
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier DAVID M. HAHN			
	29c. License number 020396				29d. Date signed (Month, Day, Year) September 1, 2000			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID HAHN, M.D., 5601 LOCH RAVEN BLVD., SUITE 107, BALTIMORE, MARYLAND				31. Date filed (Month, Day, Year) SEP 06 2000			
	32. Registrar's Signature B. Sparks				33. Date of Death SEP 06 2000			

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene

00 27994

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Helen Spence		2. Date of Death Month Day Year AUG. 29 2000		3. Time of Death 4:35 AM
	4a. Facility Name (If not institution, give street and number) St. Agnes Nursing Home & Rehab.		4b. City, Town, or Location of Death Ellicott City		4c. County of Death Howard
Funeral Director	5. Social Security Number 107-05-0367	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	8. Date of Birth (Month, Day, Year) June 1, 1916	9. Birthplace (State or Foreign Country) New York
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10e. State MD	10b. County Carroll	10c. City, Town or Location Woodbine		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	10e. Street and Number 2825 Florence Rd.		10f. Zip Code 21797		10g. Citizen of What Country? USA
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: white		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker
	17. Father's Name (First, Middle, Last) Edward McGloughlin		18. Mother's Name (First, Middle, Maiden Surname) Catherine Brady		16b. Kind of Business/Industry Own Home
	19a. Informant's Name/Relationship (Type, Print) Barbara C. Spence - daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2825 Florence Rd., Woodbine, MD 21797		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Hope Cemetery		20c. Location - City or Town, State 8/31/00 Hasting-on-Hudson, NY
	21. Signature of Funeral Service Licensee [Signature]		22. Name and Address of Facility Gary L. Kaufman Funeral Home 7250 Washington Blvd., Elkridge, Md. 21075		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cerebral Thrombosis Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined					
28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier [Signature] Dr. Salehiani					
29c. License number D 28595					
29d. Date signed (Month, Day, Year) 8/30/00					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TASNEEM LAKHANI, 7220 PARK HEIGHTS AVE BALD MD 21208					
31. Date filed (Month, Day, Year) SEP 06 2000					
32. Registrar's Signature [Signature]					



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State of Maryland / Department of Health and Mental Hygiene

00 27995

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>VIOLA SPRINGFIELD</b>		2. Date of Death Month <b>September</b> Day <b>1</b> Year <b>2000</b>		3. Time of Death <b>5:08 a.m.</b>
	4a. Facility Name (If not institution, give street and number) <b>Harbor Hospital Center</b>		4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>
Funeral Director	5. Social Security Number <b>214.22.6843</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age <b>73</b> yrs. last birthday Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>May 5, 1927</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent		10c. City, Town or Location		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10a. State <b>Maryland</b>	10b. County <b>Anne Arundel</b>	<b>Pasadena</b>		
	10e. Street and Number <b>1556 Wall Drive</b>		10f. Zip Code <b>21122</b>		10g. Citizen of What Country? <b>U.S.A.</b>
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+)		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Teacher</b>		16b. Kind of Business/Industry <b>Education</b>		
	17. Father's Name (First, Middle, Last) <b>Louis Voland</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Viola Trogler</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Viola Harcourt/Daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1558 Wall Drive Pasadena, Md. 21122</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Meadowridge Mem. Park</b>		20c. Location - City or Town, State <b>Elkridge, Maryland</b>
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Gary L. Kaufman Funeral Home at Meadowridge Memorial Park 7250 Washington Blvd. Elkridge, Md. 21075</b>		
Physician /Medical Examiner	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) <b>Sepsis</b>				<b>20 days</b>
	Due to (or as a consequence of): <b>Urinary Tract Infections</b>				<b>20 days</b>
	Due to (or as a consequence of): <b>Cerebrovascular accident</b>				<b>8 years</b>
Medical Certification: To Be Completed by Physician/Medical Examiner	23a. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Renal Failure, Diabetes Mellitus</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
	<b>Thrombocytopenia, Chronic Respiratory Failure</b>				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M
			28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
			28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28t. Location (Street and Number or Rural Route Number, City or Town, State)
	29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
	29b. Signature and title of certifier 		29c. License number <b>Res 001</b>		29d. Date signed (Month, Day, Year) <b>September, 1, 2000</b>
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>KOUROSH DIBADJ 3001 South Hanover Street, Baltimore, MD 21225</b>				
	31. Date filed (Month, Day, Year) <b>SEP 06 2000</b>		32. Registrar's Signature 		

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27996

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Peter PAUL Tokasz

2. Date of Death

Month Day Year  
August 29, 2000

3. Time of Death

18:32 PM

4a. Facility Name (If not institution, give street and number)

HARBOR HOSPITAL CENTER

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore City

Funeral  
Director

5. Social Security Number

186 14 4203

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

June 29, 1915

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

311 - 16th Avenue

10f. Zip Code

21225

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
6th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Spot Welder

16b. Kind of Business/Industry

General Motors

17. Father's Name (First, Middle, Last)

Blazie Tokasz

18. Mother's Name (First, Middle, Maiden Surname)

Nillie Zuraf

19a. Informant's Name/Relationship (Type, Print)

Mary Tokasz / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

311 - 16th Avenue Baltimore, Maryland 21225

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holy Cross Cemetery

Date

9/1/00

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Donna M. Brzezinski

22. Name and Address of Facility

Gonce Funeral Home P.A.  
4001 Ritchie Highway Baltimore, Md. 21225

Physician  
/Medical  
Examiner

23a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. RESPIRATORY FAILURE

Due to (or as a consequence of):

b. Sepsis, Pneumonia

Due to (or as a consequence of):

c. CARCINOMA of PROSTATE, CARCINOMA of Lung

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

V. Galekowsky, MD

29c. License number

DBS 000

29d. Date signed (Month, Day, Year)

August 29, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

345 CANTWATER CT, Apt #201, GLEN BURNIE, MD 21061

31. Date filed (Month, Day, Year)

SEP 06 2000

32. Registrar's Signature

Ben Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27997

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ethel Turner				2. Date of Death Month Day Year August 30, 2000		3. Time of Death 1:45 PM	
	4a. Facility Name (If not institution, give street and number) Spa Creek Center at Genises Eldercare				4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 215-12-3390	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 96 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 3/13/1904		9. Birthplace (State or Foreign Country) N. Dakota
	Usual Residence of Decedent							
10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Linthicum			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No XX	
10e. Street and Number 6445 St. Phillip Road				10f. Zip Code 21090		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk			16b. Kind of Business/Industry Q.M. Laundry	
17. Father's Name (First, Middle, Last) Foster Gover				18. Mother's Name (First, Middle, Maiden Surname) Amelia Davis				
19a. Informant's Name/Relationship (Type, Print) Gloria Minarik - daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6445 St. Phillip Rd., Linthicum, MD 21090				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven		Date 9/1		20c. Location - City or Town, State Glen Burnie, MD		
21. Signature of Funeral Service Licensee <i>Kelly Gregory Fink</i> Kelly Gregory Fink				22. Name and Address of Facility FINK FUNERAL HOME, PA 426 Crain Hwy., SW, Glen Burnie, MD 21061				
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Cerebrovascular Vascular accident</i> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <i>1 week</i>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>D. Singh MD</i>				29c. License number D38958		29d. Date signed (Month, Day, Year) 8/31/2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Daljeet Singh Gill 1413 Elmwood Road #106 Odenton MD 21113</i>								
31. Date filed (Month, Day, Year) SEP 06 2000		32. Registrar's Signature <i>B. Sparks</i>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27998

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CHARLES HILTON TOOGOOD				2. Date of Death Month Day Year September 3, 2000		3. Time of Death 7:08 PM	
	4a. Facility Name (If not institution, give street and number) Sinai of Baltimore				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 217.14.0694		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 18 Yrs.		8. Date of Birth (Month, Day, Year) 07-17-22	
	9. Birthplace (State or Foreign Country) MD		10a. State MD		10b. County N/A		10c. City, Town or Location BALTIMORE	
10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 1244 NORTHWICK ROAD		10f. Zip Code 21218		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH GRADE		College (1-4 or 5+) 2 YRS		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MECHANIC		16b. Kind of Business/Industry ADVERTISING		
17. Father's Name (First, Middle, Last) RICHARD TOOGOOD				18. Mother's Name (First, Middle, Maiden Surname) AGNES GREEN				
19a. Informant's Name/Relationship (Type, Print) DANIECE DENNIS DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3308 LUDGATE RD., BALTO. MD. 21215				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify):		20b. Place of Disposition (Name of cemetery, crematory or other place) BALTIMORE NATIONAL		20c. Location - City or Town, State 9-8-00 LAUREL, MD		20d. Date		
21. Signature of Funeral Service Licensee [Signature]				22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL PIKE, BALTO. MD. 21229				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Sepsis Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death 2 Days		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		
28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Helen Z. Norwood, M.D.		
29c. License number Res 000		29d. Date signed (Month, Day, Year) September 3, 2000		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Helen Z. Norwood, M.D., 2401 West Belvedere Avenue, Baltimore, MD		31. Date filed (Month, Day, Year) SEP 06 2000		
32. Registrar's Signature [Signature]		33. Registrar's Signature [Signature]		34. Registrar's Signature [Signature]		35. Registrar's Signature [Signature]		



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27999

Amended Item#5,15,16a,16b per FHG787 9/21/2000 EW Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

SEBASTIAN EVAN VASQUEZ

2. Date of Death

Month August Day 28 Year 2000

3. Time of Death

8:04pm

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

NONE

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth (Month, Day, Year)

1 34 AUG 28 2000

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

HARFORD

10c. City, Town or Location

HAVRE DE GRACE

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

102-15 BAYLAND DRIVE

10f. Zip Code

21078

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☒ Never Married ☐ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☒ Yes ☐ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

NONE

16b. Kind of Business/Industry

NONE

17. Father's Name (First, Middle, Last)

BERNARD P. VASQUEZ

18. Mother's Name (First, Middle, Maiden Surname)

HEIDI E. REICH

19a. Informant's Name/Relationship (Type, Print)

MR + MRS BERNARD P. VASQUEZ

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

102-15 BAYLAND DRIVE HAVRE DE GRACE, MD. 21078

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CENTRE CEMETERY

Date

SEPT-1, 2000

20c. Location - City or Town, State

FOREST HILL MARYLAND

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

EVANS FUNERAL CHAPEL - BELAIR, P.A. 21050  
3 NEWPORT DRIVE FOREST HILL MARYLAND

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Hypotension

Due to (or as a consequence of):

b. extreme Prematurity

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

94 minutes

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient

☐ ER/Outpatient

☐ DOA

Other:

26. Place of Death (Check only one)

☐ Nursing Home

☐ Residence

☐ Other (Specify)

27. Manner of Death

☒ Natural

☐ Pending investigation

☐ Accident

☐ Suicide

☐ Homicide

☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury et Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D42821

29d. Date signed (Month, Day, Year)

8-30-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR MELINDA ELIOTT 9000 Franklin Square Drive Baltimore MD 21237

State  
Registrar

31. Date filed (Month, Day, Year)

SEP 06 2000

32. Registrar's Signature

[Signature]

ORIGINAL

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-358-0000.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 28000

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Isabella Varner</b>		2. Date of Death Month Day Year <b>Sept. 2, 2000</b>		3. Time of Death <b>11:20am</b>
	4a. Facility Name (If not institution, give street and number) <b>20207 Watersrow Terrace</b>		4b. City, Town, or Location of Death <b>Germantown, MD</b>		4c. County of Death <b>Montgomery</b>
Funeral Director	5. Social Security Number <b>175-20-7499</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>76</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>Feb. 27, 1924</b>		9. Birthplace (State or Foreign Country) <b>PA</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State <b>PA</b>	10b. County <b>Cambria</b>	10c. City, Town or Location <b>South Fork</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <b>507 Main Street</b>		10f. Zip Code <b>15956</b>		10g. Citizen of What Country? <b>USA</b>
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>		
To Be Completed by Physician/Medical Examiner	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>		
	17. Father's Name (First, Middle, Last) <b>William Hartshorn</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Margaret Hogan</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Elsie Hackman / Daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>20207 Watersrow Terrace, Germantown Maryland 20874</b>		
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Hope Cemetery</b>		20c. Location - City or Town, State <b>Sept. 5, 2000 South Fork, PA</b>
	21. Signature of Funeral Service Licensee <b>Victor P. Doda</b>		22. Name and Address of Facility <b>Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Ave. Baltimore MD 21230</b>		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Metastatic Bladder Cancer</b> Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>				Approximate Interval Between Onset and Death <b>6 months</b>
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Child's Residence</b>		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>Sept. 2, 2000</b>		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Joseph M. Haggerty MD</b>			
29c. License number <b>D32407</b>		29d. Date signed (Month, Day, Year) <b>Sept. 2, 2000</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Joseph M. Haggerty, MD 9707 Medical Center Drive, Rockville MD 20850</b>					
31. Date filed (Month, Day, Year) <b>SEP 06 2000</b>		32. Registrar's Signature <b>Benjamin S. Sparks</b>			

ORIGINAL

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